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THE UNIVERSITY OF ALBERTA

A GROUNDED THEORY INVESTIGATION OF THE PREMENSTRUM: EXPOSING THE FICTION OF IDEAL WOMANHOOD

BY

ROBYN MOTT ©

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND
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IN
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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled A Grounded Theory Investigation of The Premenstrum: Exposing the Fiction of Ideal Womanhood, submitted by Robyn Mott in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Counselling Psychology.

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ABSTRACT

Six women related their experience of severe emotional and physical pain during the premenstrum. Their account of what is labelled as 'PMS' (Premenstrual Syndrome) as they lived and described the experience, deserves more respectful treatment than a label. Therefore, having been entrusted with their descriptions of their experiences, I chose a Grounded Theory approach, to generate an explanatory theory that gives voice to the meaning of the experiences of the women who lived them. This theory explains these women's experience of the premenstrum as the inevitable consequence of living their lives in a Western culture. From the moment of birth, the conditions of their culture--being a female child in a Western culture; being a child of a dysfunctional family; and experiencing a negative introduction to menstruation--prevent the women from developing the 'primary self' that they bring with them into the world. In addition, as they live their lives in this cultural context, the repeated experiences of 'trying to be the ideal woman,' and 'failing to be the ideal woman' accelerate the process of 'losing access to the primary self.' As viewed in this theory, the 'PMS' experience is the 'turning point' for these women. For some, it is the ultimate confrontation with their 'failure as ideal women,' and until they perceive that 'trying' and 'failing' are synonymous, they stay trapped in a cycle of rage and despair. For others, their 'PMS' experience enables them to see that 'trying' and 'failing' are one, and frees them to 'expose the fiction of ideal womanhood'--the core Basic Psychological

Process that was identified by my Grounded Theory Analysis.

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A very special thank you to the three most important people in my life: my partner Kevin, my son Shaun, and my daughter Karyn. Karyn and Shaun have helped me learn what is really important about life. Kevin, you have been my greatest supporter, and many times enabled me to continue when I was ready to give up.

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1. INTRODUCTION

Menses

... It is the red flower
that blooms by the roadbed,
The dark red bird
Whose song is blood,
This miracle of you,
This dark which keeps
On bleeding, these petals
Which are always healing
Within themselves.

Robert Gibb (cited in Taylor, 1988, p.52)

Beginnings

> Research is a process which occurs through the medium of a person - the researcher - who is always and inevitably present in the research. This exists whether openly stated or not; and feminist research is out to make this an open presence ... Researchers must come out in their writings (Stanley & Wise, 1983, p.34)

In all research endeavors the researcher brings to a study personal beliefs, values, and life experiences. The idea of beginning this research emerged from listening to women's stories about how their 'PMS' experience was destroying their lives, and from reflecting on my premenstrual experience.

A few months after the birth of my first child, I began to feel as if I was crazy. I had stopped nursing him, and my body had begun to return to regular menstrual cycles. At times I couldn't sleep, would cry and scream for no apparent reason, didn't want anyone to be anywhere near me, and almost drove away those I love most.

Upon becoming aware of a cyclical nature to my difficulties, I began to search desperately in medical journals to learn more about what was happening to me. The medical journals seemed to be a reasonable place to search for information about something cyclical that was happening to my body every month. Initially I was searching for answers to the following questions:

1. Is this experience described anywhere in the literature?
2. Does this experience have a label or name, and what causes it?
3. Do other women experience this, and if so, was their experience similar to mine?
4. What have other women found to be helpful to them in managing or coping with their changes?
5. Why do some women experience dramatic changes while others hardly notice any changes?
6. What are the 'positive' aspects to menstrual cycle changes?

I quickly discovered that there were many different authors describing cyclical changes related to the menstrual cycle, and that numerous terms were used to describe the same phenomenon. My search of the medical literature (mainly biological in nature) left me confused, with more questions than answers.

The biomedical literature which I read stated that 'PMS' was a physiological condition attributed to 17 possible hormonal fluctuations. Any one of the 17 fluctuations, or any variation thereof, could cause any or all of the symptoms I was experiencing. To my great frustration, I discovered that although the biomedical literature was quite specific about the physiological origins of 'PMS,' it was not so specific about the treatments. A vast array of treatments, ranging from the elimination of caffeine to adherence to a rigorous exercise regimen, were suggested. In severe cases the recommended treatment could involve doses of estrogen or progesterone (the biomedical literature was inconsistent as to whether or not cancer risks increased). The ultimate solution proposed for intractable 'PMS' was surgical hysterectomy.

My confusion was increased by the broad range of causes and treatments proposed. Why did a vigorous exercise routine work for some women, but not for many others? Why did a low cholesterol diet combined with Vitamin B6 have a dramatic effect for some, but not others? The exhaustive list of proposed remedies was overwhelming.

It should be mentioned that many of the treatments suggested had to be implemented for an extended period of time before their effectiveness could be evaluated. Clearly, should I have been unfortunate enough not to find an effective treatment early in the list, working through the entire list would have been an exhausting process of several years duration.

My search for answers in the biomedical literature left me not only overwhelmed but also very puzzled, because there were contradictory explanations and no clear, generally accepted treatment. Thus, I turned next to the psychiatric literature.

The psychiatric literature presented me with more confusing and conflicting information. It presented 'PMS' as only being an actual premenstrual disorder if the woman had experienced none of the premenstrual symptomatology during the rest of her cycle. Given that many of the symptoms women described--myself included --were anxiety, depression, fatigue, and feelings of sadness and anger, this seemed to me to be a very narrow diagnostic limitation.

Thus, although I was frustrated, I was not surprised to discover that the psychiatric literature appeared to state clearly that many women who presented as experiencing 'PMS' were actually suffering from psychiatric problems which were only exacerbated during their premenstrum. Furthermore, the psychiatric literature suggested that women's retrospective description of their experience was inaccurate, and that prospective recording frequently revealed that many women did not suffer from 'PMS' ('PMS' as defined by the psychiatric profession). The treatments for both 'PMS' and other psychiatric conditions which 'PMS' exacerbated were prescriptions for tranquilizers and/or anti-depressants.

Consequently, I was left confused and frustrated: either I was experiencing a physical "illness" for which there was little reliable treatment, or I was suffering from a psychiatric disorder and could not accurately report my own experience. The only help available to me was anti-depressants and/or tranquilizers.

However, my own experience of premenstrual changes was somewhat different from that described in the literature, and the research still seemed incomplete. Therefore, I began to explore the sociological literature, which was also helpful in some ways, but still my understanding of the phenomenon of 'PMS' remained incomplete. My frustration with the biomedical, psychiatric, and sociological literature led me to search the feminist literature. I was impressed by the feminist viewpoint: that women do have the ability to report accurately their experiences, and that the researcher has an ethical obligation to record and respect that experience. This is the perspective that I have brought to my research.

Despite my search of the literature, I still did not know what other women had to say about their menstrual cycle changes. It seemed obvious to me that I, as a researcher, must return to the experience as it is lived as a source of knowing what the experience is (Holmgren, 1987). It is here that my research began.

Statement of the Problem

Although Frank (1931) coined the term Premenstrual Syndrome ('PMS') over 50 years ago, minimal progress has been made towards a comprehensive understanding of the complexity of women's experience of the premenstrum. Numerous professional groups have been influential in menstrual cycle research: psychiatrists, endocrinologists, gynecologists, nurses, sociologists, psychologists, and feminists. However, the research is plagued with serious methodological problems, and there is no integrating framework for the existing information. Until research gives voice to women's experience of the premenstrum, the research remains both incomplete and potentially more damaging for women than if there was no research. My research takes on particular significance, given the recent inclusion of the premenstrual experience (known as Late Luteal Dysphoric Phase) by the American Psychiatric Association, in the appendix of the diagnostic manual of psychiatric illnesses (DSM III-R).

There are dangerous ramifications in classifying women who experience 'PMS' as suffering from a psychiatric disorder, because the psychiatric model does not respect women's ability to report accurately their own experience. If we are to develop effective ways of assisting women on their journey into healing from severe premenstrual pain, women's voicing of their experience must be given prominence. Therefore, what is needed is a multidimensional theory that voices women's experience, and that addresses the complex behavioral and psychosocial processes which accompany the physiological changes of the menstrual cycle.

The Grounded Theory method provided me with the vehicle for developing such a multidimensional theory. The purpose of Grounded Theory is to understand how individuals define, through interaction, their reality. Grounded Theory is also appropriate when it is important to refocus and clarify existing research (Hutchinson, 1986; Stern, 1982). Most importantly, this method generates explanatory theories that articulate the meaning of the experience to the participants, and where applicable, frees the researcher to draw on the richness of literary works--poetry, short stories, or novels.

The theory that evolved from my research is about women's search for their inner selves. Because women reach their inner selves in many ways--mixed metaphors, images, and symbols--I have chosen to speak in many voices in order to express their stories. The rich wealth of experience, even in the midst of pain, that the women brought to their stories required that I draw upon many voices to give their collective story the variety, richness, and complexity it deserves. My search of women's literature revealed to me poems, stories, myths, and sagas which included similar words used by the women whose story I have told here.

Synopsis

Chapter 2 reviews and critiques the available literature on 'PMS' and offers some suggestions of possible ways to further enhance women's healing from their premenstrual experiences. Chapter 3 explores the Grounded Theory method and how it enhances feminist research. Chapter 4 shares with the reader the women's collective story of their premenstrual experiences, as they spoke it with me. Chapter 5 presents a brief overview of the Theory, as it evolved from the women's experience of severe premenstrual changes. Chapter 6 details the Theory of the women's journey through pain and the beginning of the journey into healing.

I do not present a theory of women's healing from their premenstrual experience. It is my conviction that, as women, we cannot collectively experience deep inner healing until our deep pain is thoroughly understood. However, my purpose in articulating the Theory of the Pain of the Premenstrum is not to leave women and those who share their story in pain.

Paradoxically, out of listening to, and sharing the six women's stories of their premenstrual pain, came a great sense of healing for me. As with all paradoxes, longer reflection revealed that there was no paradox at all. Healing can only begin from a full understanding of the pain.

The tremendous gift offered by the women who share their personal stories of pain on these pages is the beginning of a journey of healing. Therefore, Chapter 7 presents an outline map of the journey of those women who began their own inner healing process, as an offering to all women who shared, or who will share, this journey.

Chapter 8 revisits the literature highlighted in Chapter 2 in light of the theory presented in Chapter 6, and suggests the implications for counselling women who experience severe premenstrual changes. It also highlights some crucial principles that may be employed to empower women in need of many forms of healing.

Chapter 9 focuses more specifically on the critical necessity of examining the conditions and context of each individual who seeks healing. This chapter suggests that healers en-courage women to seek rituals of menstrual celebration. Chapter 9 concludes with illustrations and examples designed to empower both women and men in their understanding of how our patriarchal cultural context has injured us all. The acknowledgement of the vital gift the research and writing emerging from the Stone Center (a center for feminist research) has contributed to my ability to develop this Theory is too immense to hide away on the Acknowledgement page. The Stone Center has contributed immeasurably to the feminist material so desperately needed by feminist healers in their courageous struggle to assist women in the healing process.

2. REVIEW OF LITERATURE

Sommer (1983) proposed that there are two groups of researchers involved in menstrual cycle research. The first group focuses on the meanings associated with menstruation and the second on the relationships between hormones and behavior.

The first group comprises those researchers interested in all physiological, sociological, and personal meanings associated with menstruation in its entirety. Their studies focus on exploring two major questions and use the menstrual cycle itself as the important variable. The questions are:

1. What is the relationship between menstruation and impairment?
2. What are the effects of the menstrual cycle on mood changes?

For the second group of researchers, who focus on the broad area of interplay between hormones and behaviour, the menstrual cycle represents a naturally occurring phenomenon through which to investigate the influence of hormonal fluctuations on behaviour. According to Sommer (1983), in this body of research the premenstrual cycle and the symptoms associated with it become another variable: menstruation is viewed as the "outcome of changes in hormones, or as a reflection of beliefs about menstruation" (Sommer, 1983, p.61).

Sommer (1983) suggested that dramatically different conclusions result from the differing views of the menstrual cycle. Inadequate research methods have been employed by both groups, and thus it becomes predictable that the research regarding 'PMS' is confusing, inconsistent, and still poorly understood. Little progress has been made towards a comprehensive understanding of premenstrual changes. The lack of a consensual definition prevents any effective comparison of the existing data. In addition, treatment and evaluation strategies are based on questionable theoretical frameworks. Follow-up studies remain inadequate and results cannot be replicated. Rubinow and Roy-Byrne (1984) state that the existing body of research cannot be integrated into a comprehensive perspective due to:

1. the inattention to the formulation of a set of answerable questions prior to initiating a study;
2. the diversity in symptoms reported; and
3. the diversity of the authors' interests.

Premenstrual Syndrome encompasses a variety of somatic, psychological, and behavioral symptoms ranging in severity from mild to debilitating (Woods, Most & Dery, 1982). The literature indicates that approximately 70%-90% of menstruating women experience some degree of premenstrual change, that 30% experience some degree of recurrent disruption in their personal lives, and that 2%-8% experience severely incapacitating effects (Reid, 1985; Woods, Dery & Most, 1982). Associated psychological changes are generally reported as being more disruptive than are the physical changes (Abplanalp, 1983). Interventions have been directed towards the 2%-8% group.

'PMS' is therefore, a common phenomenon, and is experienced as problematic for many women. The literature regarding menstrual cycle changes is confusing. In order to minimize the confusion this review is divided into three parts:

1. How is 'PMS' defined?
2. What causes 'PMS'?
3) The methodological concerns about the existing research.

The first section will describe four alternative perspectives of 'PMS': the physiological, the psychiatric, the psychological, and the feminist views. The 'causes' of 'PMS' will be considered from the perspective of the psychosocial theories. The methodological concerns section will describe the inadequate research designs and strategies that have produced a questionable understanding of this phenomenon in the existing literature.

How is 'PMS' Defined?: Alternative Perspectives

Physiological Perspective

The menstrual cycle is typically described in terms of two phases--the follicular phase and the luteal phase. The follicular phase (approximately the first half of the menstrual cycle) begins on day 1 of the menstrual cycle and involves the ovarian and endometrial changes. The luteal phase (or secretory phase) begins at the time of ovulation and ends on the first day of menstruation.

The luteal phase (specifically the late-luteal phase) is focused on in the studies of 'PMS.' This phase is also referred to as the post-ovulatory phase and is characterized by the onset of ovarial secretions of progesterone. Menstrual cycle length is known to vary among women and from one cycle to the next. However, research suggests that the luteal phase generally remains constant in length from cycle to cycle. The premenstrual time during which women experience changes occurs in synchrony with the luteal phase.

Frank (1931) was the first to characterize the cluster of menstrual tension problems as a disorder that required medical intervention.[1]

While there is little agreement about 'PMS' within the medical literature, there is generally consensus regarding the following:

1. 'PMS' is characterized by a change in the reporting of 'symptoms' across the menstrual cycle (Rubinow & Roy-Byrne, 1984).
2. 'Symptoms' can be either psychological or physiological or both (i.e., anxiety, irritability, depression, emotional lability, sleeping problems, abdominal cramping, bloating, breast tenderness, headache, food craving.
3. It is essentially a self-diagnosed phenomenon.
4. There must be some 'symptom-free' time during each cycle (some researchers are more flexible and only require change in symptoms).
5. It is characterized by 'symptoms' which recur and may vary from cycle to cycle (Abplanalp, 1983).

---

[1] He described premenstrual syndrome as "emotional symptoms consisting of indescribable tension, unrest, and irritability and a desire to find relief by foolish and ill-considered actions" (Abplanalp, 1983:157).

6. The 'symptoms' typically increase in severity in the later stages of each menstrual cycle and are alleviated during menstruation (Metcalf & Hudson, 1985).
7. It is the timing of the changes that is critical, not the type of changes (Rubinow, Roy-Byrne, Hoban, Grover, Stambler, & Post, 1986).

Despite over fifty years of research, there remains disagreement about the very definition of 'PMS,' let alone etiology and treatment (Bancroft & Backstrom, 1985). To date there are over 200 possible 'symptoms' associated with 'PMS' (Price, Dimarzio, & Gardner, 1986). However, there does appear to be agreement that there are different subtypes or syndromes involved (Halbreich & Endicott, 1982, 1985; Moos, 1968; Rubinow, Roy-Byrne & Hogan, 1984). The use of the word 'syndromes' suggests that there is a recognition of the multiple complexities involved in the experience of 'PMS.'

'PMS' and the Psychiatric Research

> Hypocrites ascribed a variety of cognitive and behavioral symptoms in Sickness of Virgins to retained menstrual blood, including delusions, mania, and suicidal ideation. In the 18th and 19th centuries, mania and occasionally depression, are described in association with, or delay of menses. Icard, in 1890, described that 'The menstrual function can by sympathy, especially in those predisposed, create a mental condition varying from simple psychalgia, that is to say, a simple moral malaise, a troubling of the soul, to actual insanity, to complete loss of reason, and modifying the acts of a woman from simple weakness to absolute irresponsibility.' (Rubinow et al., 1988, p.28)

The historical associations made between premenstrual difficulties and psychiatric illness are extensive (Clare, 1985; Endicott, 1982; Halbreich, Endicott, & Nee, 1982; Rubinow et al., 1988). Clare (1983) reported that severe premenstrual complaint appears to be closely associated with mild psychiatric illness of a neurotic type. Rubinow et al., (1988) suggested that it is the frequent reporting of the psychological symptoms that supports the speculation of a relationship between 'PMS' and psychiatric disorders.

> Cyclic recurrence of exacerbation of psychiatric disorders during the late luteal phase and menstruation phase of the menstrual cycle is well described as a cardinal feature of 'atypical psychosis' as well as 'periodic psychosis of puberty'. Further evidence is suggested by numerous reports of disproportionate occurrence of suicide attempts and psychiatric admissions during the premenstrum. (Rubinow et al., 1988, p.36)

Early research from the 1950's and 1960's showed a high level of premenstrual complaining in women diagnosed as being neurotic. However, much of this research was conducted within psychiatric institutions upon women who were already labelled by society as "crazy." Another important aspect of this research relates to the problem of 'exacerbation of symptoms.' Many of the women in these studies were found to experience their psychological 'symptoms' as exaggerated during the premenstrual phase. Much of the research was devoted towards separating out these women from those for whom this only occurred in the premenstrual phase. Rubinow and Roy-Byrne (1984) concluded (based on Clare, 1983; Dalton, 1977; Smith, 1975;) that it seems reasonable to assume that any dysphoric state that is experienced in the context of the premenstrum might facilitate a gradual development of affective illnesses in individuals who are genetically predisposed. In other words, experiencing emotional malaise premenstrually could lead to the eventual development of psychiatric illness in those who have a family history of psychiatric problems.

'PMS' as a Model for Affective Disorders

It is suggested in the psychiatric literature addressing 'PMS' that this phenomenon represents one of the few states that combines endocrinology, neurobiology, chronobiology, and behavioral and social science. Therefore, despite many positions to the contrary, the suggestion is that the cyclical nature of 'PMS' "may allow it to serve as an appropriate model for other cyclic mood state disorders" (Rubinow et al., 1988, p.37).

In addition, Rubinow suggested that studying the 'PMS' experience may facilitate understanding of the 'switch process' often observed in patients with bipolar affective disorders. The reason is that 'PMS' women consistently report a dramatic change in their premenstrual and postmenstrual experience.

> The consistency and predictability of sudden state change suggests that 'PMS' may be particularly well suited for investigators of the biology and phenomenology of mood state disorders ... we may better understand the process by which biology directs the transition between experiential states, thereby enhancing knowledge of normal as well as pathologic human functioning (Rubinow et al., 1988, p.38).

Inclusion of 'PMS' in DSM III-R. In July, 1986 the American Psychiatric Association voted to include "premenstrual dysphoric disorder" (PDD) in the appendix of the DSM III-R. Rubinow et al., (1988) state that

> Irrespective of one's beliefs about the underlying causes of PDD, attempts to impose order and precision on currently arbitrary and imprecise diagnostic methods for 'PMS' should be viewed as welcome and necessary advances. (p.32)

This manual is designed to describe psychiatric disorders and is used by professionals (psychiatrists, psychologists, social workers, and other helping professionals) to diagnose mental illness. Inclusion of 'PMS' in this diagnostic manual has serious implications for it reinforces the idea that menstrual cycle changes are to be viewed as pathological.

Diagnosis of 'PMS'

In spite of the controversy pervading all aspects of research about 'PMS,' health professionals--especially physicians--are not only diagnosing women as having 'PMS' butare also attempting to provide invasive treatment for this problem.

The two main criteria currently used in the diagnosis of 'PMS' are: (a) the symptoms display particular temporal characteristics; and (b) the 'PMS' phase-specific symptoms occurring are confirmed by longitudinal, prospective charting over the course of at least three cycles. An additional requirement, as defined by the National Institute of Mental Health, is that there be at least a 30% increase in symptom severity for at least 5 days prior to menstruation.

Also suggested as criteria by Hammond (1988), is that there be an absence of psychological symptoms and marital discord during the follicular phase of the menstrual cycle, and that they be present only during the late luteal phase. Hammond (1988) further recommended that extensive psychological testing must be conducted prior to diagnosis. Instruments such as the MMPI and the Marital Adjustment Inventory must be administered during both the follicular and luteal phases, for the purposes of comparison.

Currently most diagnosis is made on the basis of the presence of 'appropriate' symptoms as self-reported by women. Little research is available delineating the effect of a 'PMS' diagnosis on a woman. However, Steege, Stout and Rupp (1988) suggest that diagnosis of 'PMS' may be both beneficial and destructive. The diagnosis may confirm the woman's role as scapegoat for problems that are, in fact, legitimate relationship problems. Personal responsibility may be assigned for personal deficiencies that contribute to 'PMS' and guilt accepted for not being able to stop the symptoms.

On the other hand, the diagnosis and subsequent viewing of 'PMS' as a 'physical illness,' in the opinion of Steege, Stout and Rupp (1988), may allow couples to approach their differences more constructively. In addition, they believe that diagnosis and confirmation of the cyclic pattern provides the professional with the opportunity to refer the woman to appropriate helping agencies.

Psychological Literature

Although the psychological, as opposed to psychiatric literature is scant, two recent psychological studies (Cumming, 1987; Montgomery, 1982) reveal important information.

Cumming's Study

The purpose of Cumming's (1987) study was to delineate the psychological characteristics of women who believe that they have premenstrual problems, seek treatment, and do not exhibit discernable psychological distress at other times. This quantitative study employed the following instruments: Premenstrual Assessment Form; Profile of Mood States; State-Trait Anxiety Inventory; IPAT Anxiety Scale; and the IPAT Depression Scale. Four groups, each containing 35 women between the ages of 20 and 45, were compared in this study:

1. "complainers"[2] with no psychiatric history who were seeking treatment from a gynecologist;
2. "non-complainers" who experienced minimal premenstrual changes;
3. women who were diagnosed by a psychiatrist as having affective disorders of a non-psychotic nature; and
4. a non-treatment community sample of women who were not aware of the precise nature of the study.

The results of this cross-sectional, comparative study do not support the contention that "premenstrual complaint" is a psychiatric pathology. Results suggested some external stress factors may be involved, and supported the need for multifactorial explanations. Women who "complained" of problems and sought treatment (group 1) reported a greater change in symptoms premenstrually than the other groups. These women were no different in mood state intermenstrually than the "non-complaining" women, or women from the general community. They were also differentiated on level of dysphoric mood from the psychiatric group. The results of Cumming's (1987) study are important in disputing the alleged linkages between 'PMS' and psychiatric illness.

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[2] This term is a direct quote from Cummings' study to describe the women who stated that they experienced PMS.

Montgomery's Study

The following is a summary of an in-depth phenomenological analysis of the premenstrual experience as completed by Montgomery (1982). See Table 1 for more details.

The paradox demonstrated in the bodily experience of the premenstrum is that of being connected and at the same time, estranged from one's own body. Consequences of this bodily experience are: a focusing inward; awareness of the body as female and capable of pregnancy; feelings of emptiness, or pride in the body's potential uniqueness; and fear of inadequacy and exposure converging with negative feelings about menstruation and femininity (Montgomery, 1982).

The paradox demonstrated in relation to the self is the mother wanting a child and the child wanting a mother. During the premenstrum, women describe times of mothering themselves. Some examples are going to bed, and eating desired foods. Although attempting to mother the self, women are found to be more successful in their mothering of others. A woman-child

Table 1

Montgomery's Phenomenological Study

Premenstrual somatic sensations signal a series of varying alterations in a women's relation to body, self, world, and time. There are new tensions, a sense of disunity, and the need for new resolution. The new relation to body, self, and world is paradoxically both a being more connected to and a being more estranged from, both pleasurable and distressing.

While premenstrual symptoms are in themselves uncomfortable, and exaggerate the felt body image, they also redirect the woman's focus inward toward her female physical self, and the resulting complex associations are both positive and negative.

Barriers, thresholds, and boundaries of the self seem to alter and these alterations are experienced as intensification, sensitivity, and responsivity within a polarized world, a world of opposites and extremes. They encourage a feeling of either undercontrol or overcontrol, either of which lead in turn to a sense of vulnerability, to self-doubt, and to withdrawal or the desire to withdraw. Although alterations occur at a level removed from manifest functioning, there is a sense of estrangement from self and world, a floating disengagement. The inner world of subjectivity is felt to move away from the everyday objectivity of the outside work/social world, which feels burdensomely demanding.

The premenstrual woman feels herself return to the ongoing dialectic of the mother-child dyad, feeling both like a mother who wants a child, and the child who wants a mother. Empathetic understanding from an intimate other reinstates a feeling of well-being, but if such relatedness is denied, or if others respond in a manner experienced as unempathetic, she is intensely reactive.

The premenstrum punctuates the flow of time. This encourages a seeing ahead and a looking back, as old conflicts, behaviors, and identifications are re-experienced and future developments anticipated. Awareness of this cycle moves the premenstrual woman to identifications greater than her own finiteness. She feels herself embedded within larger natural cycles and correspondingly more diffuse and passive.

The premenstrum also punctuates, organizes and gives meaning to behavior retrospectively considered. This retrospective attribution facilitates integration and leads to understanding and a return to patterns of behavior more consistent with her usual conception of herself. (Montgomery, 1982, p.49) needing to be mothered feels dependent and depressed and when she is denied this need, she feels estranged, tearful, and 'irrational' in intimate relationships (Montgomery, 1982).

Ordinary protective personal barriers are made more permeable during the premenstrum and thresholds are lowered. The resulting intensification can be experienced as negative, with internal images perceived as assaultive. This results in the experience of intense emotional lows and highs. The issue of self-control is heightened due to the permeability of the barriers. The premenstrual experience is perceived as being one of not being in control. Hence, women interpret their feelings of vulnerability as negative indications about themselves. They also feel overwhelmed by everyday demands (Montgomery, 1982).

Self-esteem is difficult to maintain when there is intense emotional response to personal events and conflicts are heightened. There is a return to old, less effective patterns of behaviors and a questioning of the capacity for growth (Montgomery, 1982).

The paradox evident in relationship to the women's experience of their world is that the inner world and the outer world seem to move further apart during the premenstrum. Women are likely to withdraw into the warm, vague, inner world. Accompanying this is a heightened awareness of the harshness of the outer world, and of internal conflict (Montgomery, 1982).

Functioning at work continues unimpaired 'as if on remote control' and the work world tends to recede behind a vague 'fogginess.' Here again a split occurs: being disengaged and engaged at the same time. Feelings of unreality, 'a sense of being there and not being,' and fears of exposure and frustration at the inability to speak one's inner-felt experience surface. Concurrently, feelings of being connected to the natural beauty of the world and those in intimate relationship with the self occur (Montgomery, 1982).

Feminist Perspective

Feminist researchers have written extensively about what they view as abuses of women by the traditional medical community regarding women's health issues. Only recently have feminist perspectives on 'PMS' been described in the research literature (Conn & Fox, 1980; Ehrenreich, 1983; Golub, 1986; Laws, 1982; Rome, 1986; Shuttle & Redgrove, 1986; Sommer, 1983). It is important to remember that feminist research is a relatively new perspective in its own right and that the phenomenon of 'PMS' has only received attention in the last few years.

Until now, most of the feminist research in this area has been reactive in nature. This appears to be a necessary beginning point in the initial stages of this body of menstrual cycle research. However, feminist research is not only reactive, but has also begun to be proactive (eg. Koeske, 1985). The discussion of the perspective presented here is intended to summarize the feminist view of 'PMS.'

The feminist perspective is concerned with the medicalization of 'PMS': the medical profession labels a natural, normal female physiological event as appropriate for medical intervention (Ehrenreich, 1983; Rome, 1986; Shuttle & Redgrove, 1986). According to Ehrenreich (1983), even a cursory review of the existing medical/psychiatric literature clearly shows that all aspects of female physiology are viewed through the lens of dysfunction. Ehrenreich (1983) suggested that premenstrual syndrome represents another medical myth, and that the research reinforces 'sexist' ideas that women are neurotic.

The medicalization of women's life cycle has serious implications. Viewing natural physiology as a form of dysfunction or illness necessitates ongoing treatment (Ehrenreich, 1983, p.15), and may suggest a strong anti-woman bias (Laws 1982; Rome, 1986, p.149). Such a position is a convenient and powerful manner by which to justify ignoring and invalidating women's perceived rebelliousness (Laws, 1982).

This relates to one of Rome's (1986) major concerns about the definition of 'PMS' and the research methods that have characterized the avenues of inquiry. One of the major entry criteria for participation in premenstrual syndrome studies (and a critical aspect of the definition of the 'syndrome') has been the requirement of at least one week during the menstrual cycle that is 'symptom-free.'

According to Rome (1986), the implication of a 'symptom-free' time is that a woman has a 'normal' time during which she is well-adjusted to male norms and standards. Others can ignore any behaviour that is different from that which is deemed 'normal'; hence, the anger experienced by many women during the premenstrum is discounted. Inherent in this idea is that medical intervention, particularly the use of progesterone and psychiatric medication, is an important way to "help women function more smoothly in their traditional, stereotypical role" (Rome, 1986, p.151).

Shuttle and Redgrove (1984) describe how the medical view collects and interprets the research on menstrual cycle changes to favour the specific conditions of male physiology and psychology--limited variation of emotional intensity. They describe the following scenario as representative of a process they have termed the 'howlback.'

> Say that every few days before her period a woman feels tense, is irritable, depressed and lethargic. She has a headache, breast pains, and backache. She feels raw and sensitive. She feels like an unexploded bomb. She is aware that the children are playing up to her. Her husband is being far too nice, which is irritating. She explodes at him and then feels guilty. She goes to the doctor. 'Why do I feel so ill?''You have Premenstrual Syndrome I'm afraid. It's quite usual.' 'Yes but what is the cause?' 'Please don't excite yourself. There is an accumulation of fluid in your body which may produce these symptoms. So we will try you on a diuretic. If this doesn't work, perhaps a mild tranquillizer would help. As a last resort hormone treatment is usually effective.' 'But what is the cause?' 'Ah, now I am afraid you trespass on medical preserves. It is your natural female functions which can produce these troubles. ' (Shuttle and Redgrove, 1984, p.42)

They draw the analogy of this vicious cycle process to that of an audio engineering phenomenon--that of the howlback. This occurs when the microphone is pointed towards the loudspeaker, creating a noise resembling a howl. The hum in the circuit is then picked up by the microphone, amplified, and this amplified noise is fed back into the system in a circular fashion.

Clearly, the issues from the feminist perspective are the medicalization of 'PMS,' the anti-woman bias, and the use of interventions whose purposes are to help women adapt better to traditional roles.

Unfortunately, this situation reflects the current socialization of both men and women. It appears that our socialization processes are to blame--if blame is to be laid. It is not my intention to blame either individual women, or men, or the individual branches of professional disciplines. Women tend to go to doctors more often than men do. When a physician is faced with a patient who has physical or psychological complaints of a non-specific nature, and who is saying "do something," it is in some ways understandable that the physician then prescribes medication.

What Causes 'PMS'?: Alternative Perspectives

The physiological explanations of what causes 'PMS' consider both endocrinological and genetic factors. The literature in this area is abundant. It remains beyond the scope of this thesis to comprehensively describe the biomedical research findings here. However, one of the important tenets in this work is that of acknowledging that there are complex interactions between genetic and hormonal factors which create the experience of premenstrual changes. Since the psychosocial processes of the premenstrual changes are the focus of this study, I chose not to do the medical research a disservice by reviewing such an extensive area of literature in a short space.

Psychosocial Theories

Theories that examine 'PMS' from a sociological perspective focus on the areas of social stress, social support, and sex roles. Although a feminist perspective was presented in the previous section, it will not be discussed separately here. The feminist perspective describes the cultural genesis of 'PMS' and these ideas are contained within the following review of the sociological perspective

Social Stress

This body of research is dominated by psychiatric and sociological nursing researchers. The history of the controversy about the definitional issues, and about the relationship between stress and 'PMS' parallels that of the difficulties in defining what 'PMS' is (Abplanalp, 1988, p.102). Stress, like 'PMS,' is described as an intervening variable, a stimulus and a response (Abplanalp, 1988). Research reviewing the relationship between 'PMS' and stress is limited. Such questions as: (a) Does stress cause 'PMS'?, (b) Does stress maintain 'PMS'?, and (c) Does stress exacerbate 'PMS'? are not answered clearly (or easily). The concept of stress as a response to 'PMS' is just beginning to be addressed, in spite of a history of speculations (Harrison, 1982; Weidegger, 1976).

The literature suggests that women experience more chronic social stress than men and that the female reproductive system is particularly sensitive to environmental changes and to psychological stressors (Abplanalp, Haskett, & Rose, 1980; Clare, 1985, p.478).

Wilcoxin, Schrader and Sherif (1976) studied activities and life events reported across the menstrual cycle. Their research indicates that the "phase in the cycle is less important in explaining the prevalence and timing of negative moods and states, than were stressful events reported" (Abplanalp, 1988, p.103)

Brown and Zimmer (1986) conducted an exploratory study of premenstrual changes focusing on coping strategies, personal and family impact, and alterations in family functioning. They stated that scientific studies "have virtually ignored the impact that premenstrual symptomatology has on the woman's personal life and family functioning" (Brown & Zimmer, 1986, p.31) and that premenstrual syndrome is a form of chronic illness and affects the family. Once again, menstrual cycle changes and illness are linked. In essence, this work confirms that there is a significant correlation between the degree of a woman's symptoms and the quality of the marriage, and the family cohesiveness. Both male and female partners evaluate their marriage more negatively during the premenstrum (Abplanalp, 1988, p.104).

The link between negative beliefs and menstruation can best be viewed from a historical perspective. In many cultures menstruation has been, and remains, a socially unacceptable event. Many women are isolated from the rest of the social groups in special housing, and they are considered to be unclean and unhealthy. Even in societies where the overt taboos are no longer practiced, the stigma handed down may persist.

> Depending on the culture, women will not cook, pray, exercise, have sexual relations, go out in public, and so on, when menstruating. The tremendous variety of reactions illustrates that the "illness" is not solely biological; reactions depend instead on social factors. (DiMatteo & Friedman, 1982, p.127)

As menstruation is frequently accompanied by discomfort and feelings of unwellness, it is not surprising that those whose business is illness decide that women are indeed ill.

Social Support

Although Brown and Zimmer's (1986) work was described within the model of social stress, there appears to be a great deal of overlap between their research and the research regarding social support. The common philosophy underlying these models is

> ... that casual, less intimate friends, as well as intimates afford protection from illness and that psychological symptom levels vary with social support even when there is no serious life event present. (Clare, 1985, p.479)

Clare's (1985) research indicated that a significant relationship exists between marital disharmony and premenstrual dysfunction that is independent of psychiatric dysfunction. As marital discord often encompasses issues of self-esteem, sexual concerns and sex role conflicts, Clare states that it is likely that these factors heighten a woman's sensitivity to her menstrual changes, which she might not otherwise focus on.

What Clare seems to be missing is the role of stress in influencing hormonal level and the role stress can play in interfering with the normal interaction of hormones. Stress is known to increase production of the hormone adrenalin, and heightened adrenalin levels may well interfere with the body's ability to produce normal levels of other hormones necessary to the healthy menstrual cycle. Abnormally high adrenalin levels have been known to suppress menstruation in some women.

Taylor and Bledsoe (1986) seem to be more aware of the interconnection between stress and physiology. Their work and that of Woods, Dery and Most (1982), exploring peer support groups, suggests that 'PMS' is aggravated by a lack of social support and heightened environmental stressors. They submit that it is the psycho-social changes, rather than the physical changes, that are the most disruptive factors for those women who experience extensive 'PMS' difficulties (Taylor & Bledsoe, 1986). This research supports Clare's (1985) notion that intimacy, in terms of social support, provides protection from illness and provides for healthy outcomes.

Expectations and Stereotypic Beliefs

This group of theories attempts to delineate the cultural and personal factors involved in the experience of 'PMS.' Psychoanalytic theory emphasizes the importance of interpersonal and intrapsychic variables, personality constructs, defensive styles, and femininity issues (Abplanalp, 1988, p.95). Internal psychological variables and the role of acceptance of the feminine role are critical here as contributing factors in 'PMS.' 'PMS' from this perspective is viewed as an expression of internal conflict regarding the female sex roles, in that

> the perception of menstruation may intensify a woman's preexisting conscious and unconscious conflicts about pregnancy, childbearing, aggression and penis envy. (Clare, 1985, p.479)

Karen Horney, in her essay on premenstrual tension, stated that

> The hypothesis arises that premenstrual tensions are directly released by the physiological processes of the preparation for pregnancy. I have by now become so certain of this connection, that in the presence of this disturbance, I anticipate finding conflicts involving the wish for a child at the core of the illness and the personality. And I believe that I have never been mistaken in this expectation. (Horney, 1967, p.106)

Although identifying herself as a psychoanalyst, Horney does not view 'PMS' as an inevitable aspect of being a female (Abplanalp, 1988). Shainess (1961) does postulate a direct relationship between resentment or rejection of femininity and the onset of 'PMS' symptoms (Abplanalp, 1988). More recent research, however, refuted this hypothesis. Spencer-Gardner, Dennerstein and Burrows (1984) discovered that women with 'PMS' did not differ from women in their comparison group (those with no 'PMS') in their scores on a standardized sex role inventory. The women with 'PMS' did indicate lower self-esteem and fewer positive attitudes towards menstruation than did the comparison group.

Further evidence also contradicts the notion that women are ruled by their hormones. The recent work of Rossi and Rossi (1980) and Englander-Golden (1985) suggest that both the day of the week (Monday contrasted to Saturday) and the phase of the menstrual cycle affect 'moods.'

Some sociologists (Koeske & Koeske, 1975; Parlee, 1974; Ruble & Brooks-Gunn, 1979) agree that women may experience internal conflict. They suggest, however, that it is the internalization of societal values and debilitating beliefs about menstruation, that account for unpleasant experiences surrounding 'PMS.' There are two subgroups within this orientation--those using attributional theory and those employing cognitive labelling theory. Koeske and Koeske (1975) propose that beliefs about menstruation and gender-related self-concept are linked to physical and emotional symptoms through a chain of causal attributions (Hamilton, Alagna, & Sharpe, 1985; Parlee, 1974). In other words, how women experience 'PMS' is determined by external or situational factors. These researchers suggest that when women evaluate their emotional states premenstrually, they draw on situational cues from their environment, as well as on physiological cues (Abplanalp, 1988).

Although not explicitly stated, the hormonal changes (internal factors) of the menstrual cycle could be considered to be important dispositional factors affecting premenstrual experiences. However, within this framework it is the situational factors that remain the most powerful in their effect on behaviour. In addition, Koeske and Koeske (1975) suggest that negative cultural bias towards the menstrual cycle can affect how women perceive their cycles, but that such cultural influences cannot be deemed to explain all premenstrual changes (Abplanalp, 1988, p.107).

Another perspective regarding the influence of beliefs is found in the Holistic Health literature, which suggests that it is our choices that are limited by our beliefs. This framework clearly establishes the concept of 'response-ability' for health without the accompaniment of blame. A critical assumption here is that when individuals 'choose' ill-health, it is because the choice to be healthy is "entirely or partially excluded from current life dynamics" (Peterson & Mehl, 1984, p.9).

Applied to 'PMS,' this approach suggests that there are belief systems in place for women who experience 'PMS' as a debilitating experience. These beliefs limit their ability to respond to menstrual cycle changes in a more 'healthy' way. This focus would be to develop a clear picture of what the limiting belief systems are for these women, with a view towards assisting in the process of developing alternative ones that would then open up the possibility of the choice of health.

The work of Ruble and Brooks-Gunn (1979) has been the subject of controversy as to theoretical placement: dispute exists about whether their work is best discussed as attributional theory, or whether it more correctly belongs under the label of social/cognitive labelling theory. For the purposes of simplicity, the work of Ruble and Brooks-Gunn will be included in the discussion of attribution theories. They suggest that

> the physiological changes of the premenstrual phase are unspecific in their psychological effects, but are

> given cognitive meaning (labelled) in line with what the social environment defines as the appropriate response. (Clare, 1985, p.479)

The work of Ruble and Brooks-Gunn (1979) is one of the most often quoted studies within the sociological literature. Hamilton (1985), in discussing this research, postulates that a woman's beliefs about the characteristic features of the premenstrual phase of the cycle are critical factors in shaping the individual statement of symptoms, as opposed to actually experiencing the symptoms. There is a large body of literature detailing these negative beliefs about menstruation and how they have become integrated into the culture. (For example Michelet, 1863: 'for a period of 15-20 days out of 28 days, a woman was not only an invalid, but a wounded one'). Parlee (1982) concluded that with the assignment of

> Proper values to menstruation and other aspects of the feminine experience the phantom known as premenstrual syndrome could dissolve, because premenstrual syndrome is the result of complex psychological processes arising from an interaction between physical changes and environmental factors specific to feminine sexuality. (p.129)

Abplanalp (1988) describes a major dilemma for psychosocial researchers: how to examine the role of cultural and social influences on the development of 'PMS' when the only way to access these women is through direct recruitment or self-selection. Due to this problem, it becomes almost impossible to study women who are unaware of the purpose of the study. This, according to researchers (Abplanalp, 1988), creates additional problems because both retrospective and prospective questionnaires are vulnerable to reflecting the prevailing cultural stereotypes about menstruation. Thus the data gathered from women is completed by women who are aware of the purpose of the study. Such results remain questionable when viewed in a scientific context.

Methodological Concerns

Even cursory examination of the existing literature reveals a body of research plagued with design inadequacies. Methodological concerns permeate many aspects of biomedical, psychiatric, and sociological research. Rubinow, Hoban and Grover (1988) suggest that serious methodological problems are responsible for the few answers available concerning 'PMS.'

Several major research papers have addressed the methodological problems in detail (Halbreich, Endicott & Lesser, 1985; Hall, 1985; Parry, 1985; Rubinow & Roy-Byrne, 1984; Sommer, 1983). Table 2 presents a summary of the major research design and methodology inadequacies:

Table 2

Research Design and Method Inadequacies

1. Methods of symptom evaluation: retrospective, and prospective self reports:

   -even prospective recordings of symptoms can be compromised if the rating scale for measuring symptom severity does not provide a wide enough range of dimensional options (Rubinow, Hoban & Grover (1988), p.30);

   -symptom reporting is influenced by information processing bias (Ruble & Brooks-Gunn, 1979, p.180; Rubinow et al., 1988, p.29);

   -symptoms cannot be observed by an observer;

   -retrospective assessment is not confirmed on prospective measurement -expectation determines reporting, not actual experience (Halbreich et al., 1985; Rubinow & Roy-Byrne, 1984);

   -little training is provided to subjects about self-measurement (Koeske, 1985);

   -little attempt is made to differentiate between measurement error and systematic meaningful variation (Koeske, 1985, p.10);

   -symptoms reported in association with 'PMS' are diagnostically nonspecific (no mutually exclusive clusters of symptoms can be reliably demonstrated) (Rubinow et al., 1988, p.29).

2. Timing of relevant symptoms:

   -no clear consensus on exact timing of the premenstrum;

   -first day of menstruation may reflect different cycle phase for different women (Parry, 1985);

   -recall of timing can be more inaccurate than recall of symptoms (Rubinow et al., 1988, p.30);

   -even with severe 'PMS,' the symptoms experienced across cycles may be different (Abplanalp, 1988, p.102).

Table 2 (continued)

3. Determination of intensity of symptoms:

    -confusion about clinical and statistical significance (Rubinow et al., 1985, p.470).

4. Lack of attention to measurement reactivity.

5. Failure to measure intervening variables and control for confounding ones (Koeske, 1985):

    -control group developed based on irrelevant variables;
        -incomplete understanding and application of 'control groups';
        -developed on irrelevant variables;
        -control groups contain simultaneous variations in many factors;
        -lack of double blind, placebo-controlled studies.

6. Sample selection (Rubinow et al., 1988, p.31):

    -studies to date use samples whose selection is based on subject's history, without confirmation of accuracy;
    -samples studied were heterogeneous, not representative of population of 'PMS' women;
    -only 43% of self-referred women showed clear evidence of having significant 'PMS' (Rubinow, Roy-Byrne & Hoban, 1985).

Synthesis and Critical Evaluation of the Literature

Synthesis of the literature regarding the premenstrum is difficult due to both the wide variety of approaches taken to investigating menstrual cycle changes, and the contradictory nature of the results. There are no straightforward answers to any of the issues and controversies, and a full explanation of the phenomenon remains elusive. One cannot study 'PMS' without being struck by the sheer quantity, diversity, and complexity of

> symptoms themselves, as well as the multiplicity of apparently precipitating factors, including biological, psychological and environmental. (Abplanalp, 1988, p.95)

The biomedical literature focuses mainly on internal factors, the psychosocial literature on external factors, and the feminist literature on broadening our perspective of the phenomenon. Each has contributed valuable information to further our understanding of the phenomenon of premenstrual changes.

Without the medical research we would have little understanding of the complexity of the physiological aspects, and no possibilities for treatment when, or if, medical intervention is required. Some women, who at one time experienced premenstrual changes as debilitating, have been successful in changing their experience as a result of changes in diet and exercise. For some women direct medical intervention (i.e., some form of drug therapy) has facilitated their changed experience of the premenstrum.

Psychosocial and feminist researchers/writers have enabled women to understand how internal psychological factors interplay with physiology, and how cultural values and the requirements thereof have contributed to women's experience of premenstrual changes. A review of the literature still leaves a reader asking almost the same questions that were addressed in various studies conducted in the early 1930's. The main issues still unresolved appear to be internal versus external causality, and the directionality of symptom-belief causality. Additional major issues and controversies are apparent in the literature:

1. does this phenomenon exist, or is it a created myth?;
2. no consensual definition is accepted by the different research perspectives;
3. much of the existing research has been based on inadequate research design and methods, as critiqued by the biomedical researchers themselves; and
4. which is the most appropriate approach to research--the atomistic or the holistic approach?

It is important to understand how the study of premenstrual changes has been so influenced by the biomedical model, in spite of the fact that psychosocial factors are equally, if not more important than, the biomedical ones (Keye & Trunnell, 1988, p.204). 'PMS' has been characterized by physical and behavioral changes and has been linked to a physiologic event that is assumed to have biological causes. Therefore, it has been treated by physicians with drug therapy (Rubinow et al., 1988, p.29). VanderWell (1988), in his discussion of MPD (Multiple Personality Disorder), suggests that

> Using a linear thought, and an individual pathology framework, it has been identified as a disorder for which there are formal diagnostic signs... (Vander Well, 1988, p.8)

The above might well apply to 'PMS' and may help to explain why women's reporting of 'PMS' symptomatology does not accord with the rigid diagnostic frameworks established by both the biomedical and psychiatric models.

Keye and Trunnell (1988) state that the major criticisms of the biomedical model are that it is reductionistic and exclusionary. In addition, it reduces diseases to biochemical imbalances. They also suggest that women have paid a high price for the acceptance of the biomedical model. The dominance of this model in both research and in treatment has had questionable results for women's health. The feminist literature details this high price.

Researchers of each school believe that their particular orientation is the most important, and presents the most potential for understanding. Thus, it may be germane to consider a theory related to the principles of physics--the theory of Relativity. This theory suggests that all facts are relative to the location of the observer and that facts are only consensual when large numbers of observers share the same frame of reference (Peterson & Mehl, 1984). This basic principle is not openly acknowledged in the research reviewed for this study.

Three major gaps in the existing literature seem evident:

1. a lack of qualitative research studies (since the quantitative ones have shown to be inconclusive);

2. a lack of exploration of the benefits, if any, of experiencing 'PMS'; and
3. the lack of a framework which permits integration of the existing information from all three perspectives.

Clearly a new approach is needed that encompasses the biological, sociological, and psychological aspects of the experience of 'PMS.'

Obviously, an interactional model needs to address the interplay of the physiological, psychosocial and feminist factors that contribute to the experience of premenstrual changes. Keye and Trunnell (1988) propose a 'Biopsychosocial Model,' based on systems theory, as the needed framework within which information from all orientations may be integrated. They suggest that this model addresses the uniqueness of each individual and explains how the specific combination of all factors determines the clinical expression of the phenomenon. In addition, Keye and Trunnell (1988) state the following as advantages of this model:

> 1. it eliminates the dilemmas of the biomedical model;
> 2. it explains how an individual who reports feeling ill is nonetheless diagnosed as being healthy because there is no identifiable biochemical defect to explain the illness;
> 3. it explains why some individuals experience illness and others regard the same as only an inconvenience because it assumes that the severity is at least in part determined by psychosocial factors; and
> 4. it provides the rationale for a holistic approach to evaluation and therapy. (p.204)

In addition,

> The explanation of behavior is properly a multidisciplinary effort and though based on the behavioral sciences, necessarily transcends them to involve both biology and social sciences. (Menicas & Secord, 1983, p.86)

Sociologists and feminists have contributed valuable perspectives in terms of paying attention to those cultural and societal values which influence women's experiences of menstrual cycle changes. It seems evident that there are cultural values and external factors which destructively contribute to women's experiences.

What is proposed here is that there is an urgent requirement for research that:

1. studies the everyday experience of 'PMS' as lived by women;
2. respects women's description of their experience as valid; and
3. generates new theory which adds insights into the psychosocial processes inherent in this phenomenon.

Therefore, the purpose of this study is to offer explanation of the psychosocial processes involved in living with the medically labelled phenomenon of 'PMS' through the use of the Grounded Theory method of research.

3. METHOD

...I am told I should despise this bleeding
but I don't.
I think of the Sun Dance people
who danced through pain
and sacrificed their blood for love,
the worship of their god.

We learn this every month -
the involuntary sacrifice.
We bend before our goddess,
her cold light and changing faces.
We cry in pain and secretly
we celebrate
our infinite power
the warm colour red.

Patricia Handrich (cited in Taylor, 1988,p.33).

Including the Feminist Perspective

I approached this study from a feminist perspective because this perspective offered a context that articulated my values and beliefs about the ethics of research concerning women. This is not to say that I concur with all views expressed under the label of 'Feminist'. The basic principles listed below are what I mean by 'Feminist perspective.'

1. Women should define and interpret their own experiences, and women need to re-define and re-name what others (males,or experts) have defined for them.
2. ... The personal and everyday are important and must be the subject of feminist inquiry.
3. Individual reality must not be downgraded, sneered at, or otherwise patronized.
4. Feminists must attempt to reject the scientist/person dichotomy and endeavour to

> dismantle the power relationship that exists between the researcher and researched.
>
> 5. The process of the research must be central to any account of feminist research, because without including an account of this process, the sources of the researcher's knowledge are hidden from scrutiny (and how or why she claims what she does or knows).
>
> 6. Feminist research explores the basis of everyday knowledge by starting from the experiences of the researcher as a person and those with whom she explores the phenomenon. (Stanley & Wise, 1983, p.194)

Feminist research is not opposed to theory as such when it is grounded in living experience (Stanley & Wise, 1983). This approach to theory development does, however, reject the separation of theory and experience. It views as crucial the development and use of approaches that share an interest in the personal and in focusing on the everyday as a topic in its own right (Stanley & Wise, 1983, p.200). Cook (1983, p.145), in her discussion of the assumptions of feminist methodology (the study of methods), states that there is an information gap in the existing research due to the inadequate representation of women's experience and perspective. The major characteristics of feminist research methods are best summarized by Eichler (1977), and Holmgren (1987):

Eichler (1977) states that:

> 1. Research of a feminist nature regards women as participants rather than objects.
>
> 2. Research of a feminist nature rejects men as the norm to which women are compared.
>
> 3. research of a feminist nature constructs reality by starting from a female

> perspective, which may or may not need to be modified as men are taken into account.

Holmgren (1987) suggests that in feminist research:

1. The researcher should be in contact with the people she is studying.
2. The researcher should make provision for feedback between the researcher and the participants.
3. The researcher's own participation should be a consciously used part of the research process.
4. The researcher's conceptualization and methods used for gathering information should incorporate the interests and insights of the people studied.
5. the researcher should deal with both the social context and the intricate connections between the various aspects of life.
6. the researcher should focus a continual self-consciousness on the research process itself as a part of the work.

These values correspond to my ethics about conducting research with women.

There are numerous qualitative methods that could legitimately have been chosen for this study. In my search for an appropriate method two critical factors were important:

1. the method chosen must value description, personal reflection and be sensitive to uncovering the deeper structures of the phenomenon (Holmgren, 1987); and
2. the method must be compatible with the values of feminist research, as outlined in the introduction to this chapter.

Because my question addresses the process of living with severe premenstrual changes, I was initially lead to the qualitative research paradigms, specifically Phenomenology and Grounded Theory.

Grounded Theory (Glaser & Strauss, 1967) was selected because "this method allows the researcher to gather data, build a model and develop a theory ... which explains important aspects of the phenomenon which is being investigated" (Quartaro, 1986, p.2,10). As is clearly stated in the literature, new directions for understanding the premenstrum are necessary.

In addition, Rennie, Phillips and Quartaro (1988) state that Grounded Theory is a method of choice because it:

1. provides opportunity to create theory in areas that are difficult to access with traditional methods;
2. yields access to areas of human experience that are difficult to address by traditional approaches; and
3. provides the researcher freedom to use the main work of science, thinking and discovery, in exploring complex phenomena.

In addition Glaser and Strauss (1967) make it clear that Grounded Theory frees the researcher to draw on the richness of literary work--poetry, short stories, novels, etc.--where applicable. This is particularly important in feminist research. Women's stories, their life experience, has been voiced in fiction, because, until the advent and acceptance of feminism, women dared not voice their experience except through the protective guise of fiction. The wise women of old resorted to telling the truth of women's life experience in the voice of song, saga, and myth--the truth had to be presented as fiction.

> The grounded theory approach is like a rock in the river between traditional social science research on one shore and more radical research strategies which have another philosophical base, such as phenomenology, on the other. Though its intermediate position means that it is not fully part of either group, it has the virtue of being visible from either perspective. (Quartaro, 1986, p.9)

This inductive, theory-generating method arose from the Chicago School of Sociology and has been extensively applied within the disciplines of anthropology, sociology and most recently, within nursing and psychological research. This chapter describes the process and principles of Grounded Theory research as employed in this study. First, the question of 'what is Grounded Theory' is answered. Second, the constant comparison method of data collection and analysis is described. Third, the framework of the method is explained. Fourth, the process of implementing this study is described. Ways of achieving 'trustworthiness' addresses the issues of reliability and validity within this method. Finally, the use of the Grounded theory method in feminist research is discussed.

What is Grounded Theory?

Grounded Theory is both an inductive and deductive systematic method employed for the purpose of generating explanatory theories[3] of human behaviour (Charmez, 1983; Chenitz & Swanson, 1986; Field & Morse, 1985;Glaser & Strauss, 1967; Lincoln & Guba, 1985; Stern 1980; Turner, 1981). It is the inductive process ("from the ground up"), Hutchinson, 1986, p.113) that enables the researcher to study everyday behaviors in order to generate the theory. In addition,

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[3] The theory generated represents an evolving entity (Glaser & Strauss, 1967) and is not proposed as a perfect or complete product.

> This approach is required to understand the client's perspective in a way which is relatively uncontaminated by theory derived from the expert's perspective. (Rennie, Phillips & Quartaro, 1988, p.140)

In this way the researcher can study the phenomenon as it occurs in the daily lives of those who experience it: the researcher starts from a position of wanting to learn something that is not well understood (Quartaro, 1986, p.7). The purpose of Grounded Theory is to understand how the participants define, through interaction, their reality (Hutchinson, 1986; Stern, 1982). It permits a full understanding of what "constitutes reality for an individual in a particular life setting" (Field & Morse, 1985, p.109), and attempts to "see the world as the interactants see it" (Chenitz & Swanson, 1986, p.79). Grounded Theory also serves to "initiate new theory; to reformulate, refocus and clarify existing theory" (Hutchinson, 1986, p.112). It is these features that facilitate the grounded theorist's movement from the description of behaviour to the explanation of patterns at a conceptual level and thus allows for the generation of theory. Grounded Theory assumes that "people do in fact make order and sense of their environment, although their world may appear disordered to the observer" (Hutchinson, 1986, p.113).

The process of the method is difficult to describe because descriptions necessarily involve linearity and the process of Grounded Theory method research is non-linear. Therefore, diagrams have been included for clarification. Lincoln and Guba's (1985, p.188) "Flow Chart of Naturalistic Inquiry" provides the broad guidelines for the research process of this study. Figure 1 illustrates the hierarchical and recursive nature of the grounded theory process.

> Investigators systematically categorize data and limit theorizing until patterns in the data emerge from the categorizing operation. This method requires data collection, open categorizing, memoing, moving towards parsimony through determination of a core category, recycling of earlier steps in terms of the core category, sorting of memos, and the write-up of the theory (Glaser, 1978, cited in Rennie, Phillips & Quartaro, 1986, p.141).

Numerous authors have described procedural translations of the original model of Grounded Theory as delineated by Glaser and Strauss (Chenitz & Swanson, 1986; Field & Morse, 1985; Glaser, 1978; Lincoln & Guba, 1985; Maher, 1988; Quartaro, 1986; Rennie et al., 1986; Stern, 1981; Turner, 1981). All modifications in the descriptions of the phases of the research process vary only in terminology and focus, not method. The method itself is based on the joint processes of data collection and analysis.

Thus the DNA double helix could serve as a metaphor for this method: one half of the helix represents the data collection process; the other half represents the process of data analysis. Like the double-helix, the Grounded Theory method of concurrent analysis and collection is dependent upon both halves occurring simultaneously.

Grounded Theory Method

The Constant Comparative Method of Data Collection and Analysis

Participants are initially selected on the basis of their willingness and ability to describe their experience of the phenomenon being investigated. The data collection process is

> influenced by the outcomes of the emerging analysis ... and proceeds through successive stages which are determined by changes in the criteria for selecting interviewees according to what has been learned from previous data sources. (Rennie, Phillips & Quartaro, 1988, p.142)

Two participants are selected whose experience are highly similar, for the basis of comparison (Quartaro, 1986). The protocols are then coded. This level of coding is referred to by various terms, substantive, or open codes (Glaser, 1978; Hutchinson 1986; Quartaro, 1986).

Coding involves a process of attaching a descriptive label (using the words of the participant) to each concept described by the participant. Each incident in the data is coded into as many codes as possible to ensure "full theoretical coverage ... otherwise the emerging theory will not fit the data, nor explain behavioral variations" (Hutchinson, 1986, p.120). For example, one sentence in the protocol may have more than one code assigned, or two or three sentences may be combined to form one code.

Open codes are then clustered on the basis of similar meaning. The meanings that tie "items to a cluster are symbolized as categories" (Rennie, Phillips & Quartaro, 1988, p.142). Like coding, categorizing may again be descriptive and is again based on the language of the participants. Alternatively, the categories may be construct categories. The construct categories are used to help explain the descriptive ones and the possible relationships among them. Categorizing then moves the codes to a higher level of abstraction.

The emerging categories of the two protocols are then compared for similarities and differences. Categories common to both are then combined and those unique to each are added to the composite list. As the categorizing process continues, it becomes evident that some categories define properties or limitations of others (Rennie, Phillips, & Quartaro, 1988).

Theoretical sampling begins as the next two participants are selected on the basis of the emerging categories. Theoretical sampling is simply the process by which successive participants are selected for inclusion, based on what is emerging in the analyzed data. Participants are included based on their potential ability to add richness to the emerging categories and codes. Theoretical sampling is also referred to as selective or purposive sampling (Patton 1980). In this process the researcher is an "active sampler of theoretically relevant data" (Glaser & Strauss, 1967, p.69), hence their use of the term theoretical sampling.

Analysis of the subsequent protocols proceeds as described above; hence the name constant comparative method. As more protocols are analyzed, re-examination of the emerging category scheme is conducted (Quartaro, 1986, p.6). As categories and codes from the four protocols are combined, patterns begin to emerge and new categories are generated.

The aim of Grounded Theory research is to discover the interconnections among categories, conditions, consequences, and operations: it is during this phase that the interconnections between the categories begin to emerge through patterns and linkages.

It is important for the researcher to limit theorizing about the data until the patterns emerge through the comparing of categories. Constant comparison enables basic properties to be defined; "certain differences between incidents create boundaries and relationships between categories are clarified" (Hutchinson, 1986, p.122).

It is the emergence of these hypothetical relationships which represent the beginnings of the theory. As the relationships develop, the more central categories begin to become evident; other categories combine and change position in the emerging structure (Quartaro, 1986, p.6). The central, or core categories recur frequently in the data, link the data together, and explain much of the variation found in the data (Hutchinson, 1986). One or more potential core categories may become evident.

> A core category is the one most densely related to the other categories and properties. It is often an abstract category, but is not vague. It is clearly defined due to its properties (the categories it subsumes), is sensitive to new information because it is associated with many categories, and is the last to saturate. (Rennie, Phillips & Quartaro, 1988, p.144)

Two more participants are selected and their protocols are analyzed in a slightly different manner. Most often these participants are selected based on both similarity and/or dissimilarity to previous participants. Analysis of these protocols involves searching for data that will add richness to the already established categories, or alternatively, will show the limitations of the emerging theory.

> At this stage of analysis, judgments about the pertinence of categories are made on the basis of the extent to which they contribute to the emerging structure. Categories that have few connections with it (the core category) are either dropped or collapsed into other categories. (Rennie, Phillips & Quartaro, 1988, p.144)

Saturation may take place during this phase of collection and analysis. Categories begin to saturate at different times, the more peripheral ones first and the more dense ones later (Quartaro, 1986, p.6). Saturation generally happens when the researcher has analyzed between 5 and 15 protocols (Conrad, 1978; Glaser & Strauss, 1967; Jones, 1980; Pennington, 1983; Phillips, 1984; Quartaro, 1985; Rennie, 1984). Saturation refers to

> ... the completeness of all levels of codes when no new information is available to indicate new codes or the expansion of old ones; when all data fit into the established categories, interactional patterns are visible, behavioral variation is described, and behaviour can be predicted. (Hutchinson, 1986, p.125)

The occurrence of saturation signals the researcher to transcend the empirical nature of the data and to think more intensively in theoretical terms. The major questions asked by the researcher include: (a) What is the basic social-psychological problem that these people are dealing with?; and

(b) What is the basic social-psychological process (BSPP) which helps them cope with the problem? (Hutchinson, 1986, p.122). The core category forms the basis for the emergence of the BSPP. The BSPP is the process that explains all variation in the problem being studied, predicts subsequent behaviour, and "illustrates the processes as they continue over time" (Hutchinson 1986, p.118).

Memo writing. Writing memos is the second strategy of the Grounded Theory method. Memo writing is used by the researcher as a way of recording ideas, speculations, and insights about the emerging theory (Hutchinson, 1986; Quartaro, 1986; Rennie, Phillips & Quartaro, 1988). Rennie, Phillips and Quartaro (1988) outline the following functions of the memos:

> 1. They help the analyst to obtain insight into tacit, guiding assumptions.
> 2. They raise the conceptual level of research by encouraging the analyst to think beyond single incidents to themes and patterns in the data.
> 3. They capture speculations about the properties of the categories, or relationships among categories, or possible criteria for selection of further data.
> 4. They enable the researcher to preserve ideas that have potential value but are premature.
> 5. They are used to note thoughts about the similarity of emerging theory to established theories or concepts. (p.144)

Throughout the memo writing process, memos are written about other memos. In addition, during the phase of writing the theory, memos are sorted, compared, and more memos written as the theory solidifies.

In conclusion, Rennie, Phillips and Quartaro (1988) state that there are four criteria essential for a grounded theory:

> 1. it should seem to the reader to be a plausible explanation;
> 2. it should be adequate in that it should present a comprehensive account that does not omit large or important portions of the data;
> 3. it should be grounded in terms of the appropriate procedures and thereby inductively tied to the data; and
> 4. it should be applicable and should lead to hypothesis and additional investigation. (p.145)

Theoretical Framework of Grounded Theory

Grounded Theory is based on the principles of Symbolic Interactionism. This is an approach that addresses:

1. the meaning of events to individuals in a natural setting;
2. how individuals define their reality; and
3. how they act in accordance with their beliefs.

It is concerned with everyday life and with face-to-face relationships of all kinds, wherever these interactions take place (Stanley & Wise, 1983). The critical assumptions are that the personal meaning of an experience is what guides individual behaviour, and that the experience itself is what creates meaning (Chenitz & Swanson, 1986, p.46). Human behaviour is assumed to be the result of an interaction between an object (the other) and the self, whereby the object is defined and meaning or value is attached.

New meanings can be developed only through a different interactive process. Thus, Grounded Theory adopts a non-deterministic stance towards social life and rejects the idea that people's actions are the result of 'imprinting,' 'instinct,' or 'socialization' (Stanley & Wise, 1983). Social structures are important and are viewed as social constructions produced within, and by, everyday interactions. This active process of constructing, negotiating, and interacting includes that of self with self.

Important theorists of Symbolic Interactionism are George Mead (1934) and Herbert Blumer (1969). Mead's (1934) contribution was his description of the process of the development of the sense of self. Blumer (1969) focused on the concept of 'meaning' as the guide for human behaviour.

Chenitz and Swanson (1986, p.47) describe the implications of adherence to this model for research design:

> 1. The setting, the implications of the setting, and the larger societal forces that affect behaviour must be analyzed;
> 2. A full range of variations of the phenomenon (behaviour) must be considered to produce self definitions and shared meanings;
> 3. Social behaviour must be described as it takes place in natural settings; and
> 4. The researcher must understand the behaviour from the participant's perspective, and becomes both a participant in the participant's world and an observer of the interaction. (Denzin, 1978)

Implementation of the Study

The Women

The participants in this study were six women who were willing to describe and share their experiences of menstrual cycle changes to me. They were not necessarily representative of the clinical population of women who meet the medical criteria for diagnosis of 'PMS.' They were all women who described their premenstrual changes as profoundly affecting their lives. It was not possible for me to know in advance how many participants would be involved (Field & Morse, 1985; Glaser & Strauss, 1967). Saturation occurred during the sixth interview, and a decision was made to conclude data collection.

Two participants were referred to me by other professionals, and the remaining four contacted me on their own initiative, having learned by informal means that I was exploring the experience of 'PMS.' The six women were chosen according to the following criteria:

1. They identified personal concerns with menstrual cycle changes.
2. They were willing to commit time and energy to the research process and were willing to share their private experiences with the researcher. (Holmgren, 1987)

Five of the six women were married and their ages ranged from 23 to 41. Five women had children, whose ages ranged from 1 year to 17 years. Occupations varied: two women were currently students at university; three women were gainfully employed in professional careers; and one woman stayed at home to work. The age of first noticing recurring premenstrual changes varied between 13 and 36. Four of the women had been diagnosed as 'having 'PMS' by a physician, and five of the six women used the label of 'PMS' when referring to their experience.

Four women had been involved in some form of 'treatment' for their premenstrual changes at some time. Only one woman was participating in medical treatment at the time of our conversations. The others had sought both psychological and medical assistance during the course of their experience.

Little demographic information was gathered from the women and even less is presented here. For five of the women, the issue of anonymity was important. They expressed concern about any identifying information that would enable others who might read this to know who they were. Out of a deep sense of respect for the women and their concern, I chose not to include a profile of each of the women, nor to include any information that might lead to identification. Hence, the story presented in the next chapter is a compilation of all of the six stories.

In conclusion, a quote from Holmgren (1987) seems appropriate to share my feelings about the women who shared more than their premenstrual experiences, but shared their lives and offered them as a gift to me.

> It does not seem enough to leave the descriptions of these women ... at mere demographics and rationale for selecting the number of participants. These are women who are willing to open up their private lives and experiences ... to the study and, through these pages, to the reader. Each expressed a desire to contribute her experience to further our understanding....Each seemed to indicate that sharing her experience...

> would add to its meaning if it helped others.... For me these were courageous women who were willing to expose themselves in order to help others. During the research process, I not only became fascinated with them and their stories, but gained a deep respect for them individually and collectively (Holmgren, 1987, p.55,56).

I was fortunate in finding variability among the women I talked with, without having to seek it out. One woman had been experiencing severe changes since adolescence and had not found ways of healing in the ways she needed. Three women had been experiencing severe premenstrual changes for a few years and had discovered some ways of healing. The last two women were well along in their own healing process.

The Process

Prior to beginning this study, in January 1988, a colleague was asked to interview me about my own experience of, and reflections on, the premenstrum. This step was critical for two reasons:

1. To clarify the researcher's beliefs and biases about her own experience and about the phenomenon.
2. To enable me to gain experience about how it feels to be a participant in this study.

I transcribed this conversation and subsequently worked with a colleague, who had no background in the content area, to analyze the protocol. This process enabled me to bracket my own assumptions and set them aside while I continued with the research process.

Grounded Theory not only acknowledges the interaction between researcher and participant, but stresses the importance of the relationship as critical to the gathering of rich data. Bracketing is the process by which

> The researcher's biases are limited, specified, and made part of the research process.... to identify my own assumptions and values as clearly as possible, to state them explicitly, to move beyond them into reports of experience developed with the research participants, and to be vigilant about the effects of researcher bias on the data and emerging theory.... Explicit identification of biases encourages the investigator to focus on those possibilities which seem more probable than others and to bring such hunches into awareness instead of suppressing them. (Quartaro, 1986, p.16,17)

In addition, I utilized the strategy of memo writing to further bracket my own biases as I continued to listen to the women and to write their story.

The first conversation was recorded in February, 1988 with a woman who described her premenstrual experiences as "causing minor difficulty in my life." I transcribed this conversation and put it aside, without analyzing it. One of the checks in conducting Grounded Theory research, is to keep one transcript aside to be analyzed only when the theory has been developed. The purpose of this is to analyze this protocol with the Basic Psychological Process (BPP) and accompanying categories to ensure that the theory 'fits.'

The only instruments used to facilitate this study were audio-taped conversations with the women who agreed to participate. Contact with prospective participants began in March 1988, and each woman was contacted by telephone to explain the research process.

During telephone contact the purpose of the research was explained to each woman. Issues of confidentiality, the nature of the conversations, and approximate time commitments for the conversations were discussed. Participants were also told that any desire to decline participation would be respected.

Each woman was told that conversations would be 60-90 minutes in length and would be tape recorded. The possibility of second and third conversations was also discussed. I also told the women that I was conducting this research partly due to my own experiences of 'PMS' and that I had recently asked a colleague to tape record a conversation with me about my experience. Participants were provided with the choice of various places to conduct the conversations. Four women chose to talk with me in my office, one to talk with me in her office, and one to talk in her home.

At the beginning of each initial conversation, the consent form was explained to each woman and then signed. Each was also told about the confidentiality policy. Dissertation committee members were the only ones who would possibly read the transcripts and all identifying information would be removed during the transcription process. It was also explained that I would be the person transcribing each conversation and that if, at any time they preferred that something they said not be included in the transcript, this would be respected. They were also told that if at any time and for any reason, they wished to discontinue their participation, this too would be respected.

All conversations began with the suggestion to begin wherever seemed appropriate to them in order to share their story. At times both the participants and myself were moved to tears, as women's pain was shared between us. I tried to keep my interruptions to a minimum, but because of the nature of the stories, I felt it necessary to not only listen, but to share where appropriate and to offer support and validation. " The conversation was designed to open the women's experience ... as she lives it, and to bring ... past and current experience into the present so that we could get to know it in a new way as it was being told" (Holmgren, 1987, p.59).

I transcribed all conversations to protect anonymity and to immerse me in the stories. The number of conversations varied for each participant, and ranged from one to three. The number of conversations with each was only determined by their energy and the available time.

For those who met with me more than once, the transcripts were sent to them prior to subsequent interviews. They were asked to read the transcript and make any corrections. The transcript was also used as a springboard for the next conversation. The women were asked at the beginning of subsequent interviews about their experience of the first conversation, and given the opportunity to share anything that had not been told during the previous conversation. In addition, I took the opportunity to fill in what were, in her mind, 'gaps', and to explore hunches and possibilities.

For each set of two women, the conversations were analyzed according to the data analysis process described in this chapter. The last conversation was conducted in January 1989. Throughout the period of March 1988 to January 1989, the constant comparison method of analysis, and memo writing were employed as the theory emerged.

Protocols were re-read and re-listened to during this time. All except two women reviewed their transcripts, and one woman invited her partner to read the transcript as a way to help him in his attempts to understand her experience. All agreed that participating in this research had been helpful to them, and one woman commented that she could not believe what she had been willing to share.

Achieving Trustworthiness

Trustworthiness (Lincoln & Guba, 1985) is the global qualitative term for objectivity which, in quantitative methods, accounts for validity and reliability. Numerous authors (Denzin, 1978; Kirk & Miller, 1986; Lincoln & Guba, 1985) have documented the need for a different terminology to be used in qualitative research, because of the very different assumptions about the nature of truth.

The audit trail (described in Lincoln & Guba, 1985) is one of the basic strategies required to ensure trustworthiness. Moreover, it is what enables others to follow or audit the research process. Memos were kept by the researcher throughout the study to provide an ongoing record of the details required by the audit trail.

Threats to Credibility

The issues of reliability and validity are important to address in all methods of research. There is no attempt in Grounded Theory to deny that the participant observer at least initially influences the setting and the conversations (Hutchinson, 1986).

Subjectivity. Rennie, Phillips and Quartaro state the following paradox for qualitative researchers:

> As inductivists, Grounded Theory researchers are faced with the following paradox: to attempt to rid the self of preconceptions about the phenomena under investigation so that its 'true' nature will emerge in the analysis. (1988, p.141)

They consider that this can never fully be achieved. However, researchers are aware of this problem and make every attempt to identify and record biases throughout the development of the theory.

In this study bracketing was conducted in two ways. First, the researcher participated in an interview about her experience and subsequently analyzed the transcript. Second, the researcher used memos to record her ideas, beliefs and thought processes while she was analyzing the data. Berger and Kellner state that

> If bracketing (of values) is not done, the scientific enterprise collapses and what the researcher then believes to be perceived is nothing but a mirror image of his own hopes and fears, wishes, resentments or other psychic needs; he will then not perceive anything that can reasonably be called reality. (1981, p.52)

Verbal reports as data. The use of verbal reports as data is another important threat to credibility in scientific research. Rennie, Phillips and Quartaro (1988) accept this but comment that when using Grounded Theory, there is no other way to understand the meanings and experience of the participants. In addition they state that it is possible that researchers can be misled by participants who may misrepresent their process. However, a principle of feminist research is that women can validly report their own experience as they know it and it is the feminist perspective that forms the guiding principles for this research.

Generalizability

Grounded Theorists present varying perspectives regarding the issue of generalizability. Quartaro (1986) states that, in fact, the small, non-random samples do not permit generalization to other populations. However, Hutchinson states that

> A substantive theory can only be valid for the studied population. A quality theory will inevitably identify a BSP (Basic Social Process) that is also relevant for people in general. (1986, p.116)

The BSPP (Basic Social Psychological Process) represents a hypothesis theory, not a fact.

Replicability

Replicability addresses the issue of whether another researcher, adhering to the same research process, would obtain the same results. Acknowledging that the theory is only as good as the researcher (Quartaro, 1986), Grounded Theorists believe that

> Replication of findings across small groups leaves the Grounded Theorist between an individual case study and the group approach to research. Unlike the case study, Grounded Theory emphasizes the necessity to replicate evidence across more than one participant. (Rennie,

Phillips & Quartaro, 1988, p.147)

The process of Grounded Theory research is such that the researcher is forced to stay grounded in the data. It is acknowledged and valued that different researchers may study the same area and emphasize different aspects. However, it is expected that if the method is followed as outlined, other researchers will observe what the first researcher observed.

In essence it is the strategies of the constant comparison method of analysis, of memo writing, and of leaving an audit trail that ensure that credibility is maintained. In addition to these, the researcher participated in a study group with other Grounded Theory researchers. Meetings were held regularly and the group reviewed the process of analysis each step of the way.

Ethical Considerations

Ethical considerations must be addressed in any research endeavour, and involve preparation and protection of the participants. Protection of the participants involves the calculation of personal risks and benefits. The focus is modified throughout the process and the researcher does not know in advance what will be discussed during the interviews (Archbold, 1986, p.157).

The researcher/participant relationship in this study also involves several ethical issues. One ethical issue involved the necessity to insure that the participants were adequately informed about the research and could thus make an informed choice about their participation. Another ethical concern was the power differential between the researcher and the participants: I had a responsibility to recognize and not abuse the power differential which might have existed from the participant's perspective.

This is important in the interaction between researcher and participants during the data collection, and is particularly crucial at the time of termination of the relationships. Data collection in this study clearly represents a form of intervention and must be acknowledged as such: the participants' statements that discussion of their premenstrual experience with the researcher was helpful to them confirms that the sharing of experience is a form of intervention.

Focusing on any personal experience can allow unanticipated feelings that might require professional attention to surface. In such circumstances, it remains unethical for the researcher to provide such a service for the participant. However, wherever appropriate, the researcher must assume the responsibility of providing support and referral to the appropriate professionals.

I met with all prospective participants prior to the initial interview to discuss the nature, process and purpose of the research project. Prior to the first interview, each participant was required to sign the Informed Consent Form (Appendix, Table 4). As much as possible I discussed any risks associated with participation.

It was made clear to the participants that because of the personal nature of the information discussed, there might be times when the participant wished to withdraw specific details or to withdraw from the project completely. The participant's right to either of these options was stressed. Preparation of participants also involved a discussion of how the information would be used and who would have access to it.

All personal identification information was removed from the transcripts and participants' names were replaced with pseudonyms. As the researcher was involved with a research seminar group (as part of Grounded Theory method--Field & Morse, 1985) participants were informed that the information might be discussed anonymously with this group and the dissertation committee.

Termination of any prolonged relationship can be difficult and was dealt with in a supportive and sensitive manner. All participants were invited to contact me at any time during or after our conversations. Some of the women did contact me subsequently to discuss appropriate professional referrals.

Grounded Theory: A Bridge Between 'Feminist Personal' and Logico-Deductive Research

In "Re-thinking what we do and how we do it: a study of reproductive decisions," Currie (1988) proposes that Grounded Theory is a method of research particularly suited to feminist research. She states that Grounded Theory bridges the gap between subjective experiential research and logico-deductive research.

A major debate within the social sciences is the validity of experientially subjective research versus scientifically objective research. Historically, feminist researchers have, historically, taken the position that research about women must be experiential: "women's experiences constitute a different view of reality and a different way of making sense of the world (Stanley & Wise, 1983)" (Currie, 1988, p.232).

This position, in my view, is both valid and essential to ensure that research concerning women respects women's experience. Furthermore, it is crucial that feminist theory should avoid the error of becoming 'expert's theory': women's experiences that do not fit the theory should not be discounted, nor should they be denigrated as "falsely conscious" (Currie, 1988, p.233).

The experiential position has been instrumental in the creation of research that respects women, and provides much of the research literature available that advances our knowledge and understanding of how women live their lives. However, the either/or position regarding feminist research poses a serious dilemma for feminist researchers. It limits the choices available and focuses attention away from the more important issue of the crucial necessity of generating much needed research for women.

Currie (1988) stated this problem directly:

> In particular, conceptualizing our research choices as between masculinist scientific objectivity and feminine intuitive subjectivity - outsider versus insider views - is a no win situation. (p.233)

Currie (1988) proposed that one difficulty of focusing only on the experiential is that this creates a situation in which it is very difficult for the researcher to study structures and institutions. As structures and institutions may well be "oppressive forces," (p.233) and may be imposed upon the individual from outside everyday life, it may be dangerous not to study them objectively (Currie, 1988).

Why the danger in not studying structure and institutions 'objectively?' It is neither fair, nor realistic to expect research participants to be able to identify, name, or label the various structures and institutions within their culture that affect their lives and experiences as they live them.

Thus, if research is limited to the experiential, the researcher can be in a questionable position. When the researcher develops theory that involves the influence of structures and institutions upon the lives of the participants, the researcher can be asked to verify the validity of these influences. However, if the recorded interviews (i.e., the experiential data) do not include literal verbal references to the structures and institutions, the researcher is not only without the readily provable validation for the theory, but can also appear to have interpreted the data according to her/his own bias.

Currie (1988), in her article "Rethinking what we do and how we do it: a study of reproductive decisions," states the necessity of both experiential and objective research methods.

In conclusion, this study does more than add to our understanding of decision-making by giving visibility

> to women's experiences. It challenges established theory by recognizing how the normal practice of social science research obscures the structural roots of women's oppression through the development of paradigms which portray decisions as the outcome of entirely cognitive assessments. As we have seen, feminist approaches which begin from the experiences of women as a rejection of established theory often perpetuate this process by emphasizing women's accounts as self-evident explanations. Contrary to the claims of Stanley and Wise, this study illustrates the necessity to transcend the purely personal worlds of women. (Currie, 1988, p.251)

Currie (1998) proceeds to state that she began her research by "experiencing the experiences" (p.251) of the women research participants, but that her task included "explaining the explanations" (p.251) of the women. Currie (1988) next states

> Against feminist approaches which portray the separation of the personal and the structural as a false distinction, this research suggests that what we need is not a research choice between 'structure' or 'people,' but rather ways of conceptualizing relationships between the two. (p.251)

Currie (1988) advocated Grounded Theory as a method that is highly appropriate to the resolution of the research dilemmas outlined above. In addition, Currie (1988) also advanced the following reasons for Grounded Theory's appropriateness to Feminist research:

> 1. ... Grounded Theory demands that the hypotheses and concepts are not only drawn from the data, but that they are worked out during the course of the research;
>
> 2. In this way, generating the explanation cannot be separated from the process of conducting research;
>
> 3. The task is not to provide a 'perfect' description of a phenomenon (an impossible task at best), but to develop a theory that accounts for much of the relevant behaviour;

4. Both categories and their properties are indicated by the data (and are not the data themselves);

5. Overall, Glaser and Strauss emphasize theory as a process; that is, theory as an ever-developing entity rather than a perfect product;

6. Glaser and Strauss note that informed 'hunches' are often the prelude to major scientific discoveries, although retrospective accounts of the process of research often obscure this point;

7. The source of these hunches is the sensitive insights gained via the researcher's intimate association with - rather than distance from - the data; and

8. Furthermore, Glaser and Strauss (1967:252) add that crucial insights may come from the researcher's personal experiences prior to, or outside the research. (p.235,236)

Summary

This chapter began by delineating what I meant by a Feminist perspective. Next, I described the method of Grounded Theory as originally developed by Glaser and Strauss (1967), and subsequently expanded by other researchers. Finally, I outlined the appropriateness of Grounded Theory to research from a Feminist perspective as discussed by Currie (1988).

In concluding this chapter, it is important to state that, as acknowledged and accepted within Grounded Theory (see 6, 7, 8 above), I brought a hunch to this research. My hunch, based on my personal experiences with other women (Glaser & Strauss, 1967, p.252), was that 'PMS' was a metaphor for women's experience as they lived their lives in this time, in this culture (Johnson, 1987). However, I had no idea what the metaphor represented. My theory as to the nature of the metaphor grew out of the research process and is based on the women's experience as they told it, and the research categories as they emerged.

4. THE STORY

The petals of the red flower open.
Odd that something so freshly bloomed should flow so quickly to the ground.
There is no mourning for the fallen petals.
This blossoming has been long awaited, the scarlet petals bring relief.
It is the bud which breaks the bow.
Holding it hidden within the womb is pain beyond endurance.
This budding is the pain which blossoming can free.
The womb-self has boughed to hiding and if this bent bough can connect its budding to its blossoming, a new healing can begin.

(Gayle Munro, 1989)

This is the story of the women and their pain as they shared this experience with me. They share their feelings of the premenstrual time as one of budding into pain. The blossoming flow of their menstruation brings surcease.

The Story Begins

Each woman's premenstrual experience is unique and rooted in her unique history: the generic labelling and categorizing of the women as having 'PMS' denies the impact of their history on their experience. Four women speak about experiencing abuse of a physical, emotional, or sexual nature early in their lives. For the two women who speak of physical and emotional abuse, the abuse continued over the course of their growing up, until they left their family home.

> I came from an alcoholic family and I can't tell you how many Christmases were wrecked because Dad would be passed out somewhere - and that is just one example. I can remember my father emotionally abusing me (that's what I call it now, then I thought it was normal) from the time that I was small. He abused, ridiculed and

> frightened us, all except my brother and I guess that it went on until I left home around 19.

Of the two women who had experienced sexual abuse, one discussed the experience: "I was raped when I was 15." The other woman finds it too painful to discuss, stating that the ongoing sexual abuse began when she was 10 years old. She cannot discuss the abuse, but alludes to it instead (making the age of onset very clear), with the hope that she can address this later in her life.

Adolescent Experiences

None of the women discuss their growing-up years in detail. One woman says that "I just can't bring myself to go back over that time." Another states, "I really don't remember much of my early life."

Early Menstrual Experience

Great variability is revealed in the women's adolescent menstrual experiences. Recollections of each woman's early menstruation vary: descriptions range from extreme physical sickness to little memory of the event. One woman recalls that she experienced extreme vomiting and physical "sickness" just as her menstruation would begin. She speaks of having to "rush out of class in order that no one would see me throw up" and of being "very embarrassed when I would find my chair stained with blood, because I would not have any warning that I was starting my period."

Another woman speaks of being almost unaware of her menstrual cycles. Two women were taking birth control pills early during adolescence and one states, "It would just happen, and didn't really affect me, except that I had to be sure to have tampons with me." The other woman states, "I just had my period, no big deal, that's just the way it was for me."

Only two of the women can recall how they learned about menstruation. One woman began to menstruate at age 10 and was thankful that her mother had given her the basic information a few weeks before. "Even though she had told me, I was still frightened when I saw blood running down my legs." She also describes how this conversation with her mother was

> held in private and there appeared to be something secret about it because I can remember my mother saying to my father that she wanted to talk 'girl talk' to me and for him to leave us alone.

Although many of the women cannot recall specific incidents surrounding early menstruation, they all say that they were given the message that menstruation was not to be discussed publicly. "The school nurse talked about what would happen to us every month, but the boys were never there." One woman recalls being told to "hide the evidence" and

> never to walk into the kitchen with a soiled pad; it was always to at least be wrapped up. My mother told me not to place the pads in the garbage in the bathroom, because it was not emptied often and she said it would smell.

All the women, except one, describe little discussion among their female friends about menstruation. "The only thing we ever talked about was whether pads were better than tampons; nobody ever said much else." Another woman states: "I can remember being really angry and resentful at my friends who hardly even knew that they were menstruating."

The Beginning of Awareness of Premenstrual Changes as a Problem

In response to the question how did this experience begin for you?, all but one woman state that premenstrual changes become problematic for them during their early thirties. Four state that problems began following the birth of their first child. "The problems started for me six months after my baby was born." One of the women says that "it began for me when I was 13, it's just that I didn't have any term to describe it." For the other woman, premenstrual difficulties began "sometime when my children were young."

For these women, menstrually related changes appeared unexpectedly. "I just started crying and feeling out of control every month, and it just started so suddenly." However, during further discussion, all except two of the women say that as they looked back, it became more evident that problems began for them during adolescence.

> I was a teenager. I didn't really think about when things really began until you asked the question and when I thought about it, I realized that I would experience deep depressions on a recurring basis, that I think were related to my cycle.

A Time of Not Knowing

All of the women described a time of 'not knowing': a time during which they experienced problematic menstrual changes, for which they had no name. For many of them, changes were happening but they were unaware of a cyclical pattern.

> It was a long time before I realized the possibility that there was a connection between how I was feeling

> and the time of the month.
>
> I wasn't bothered by my moods, but others were, so that it took me a long time to start making a connection to my cycle.
>
> As a teenager I more or less accepted what was happening to me every month, and tried to carry on as best I could. I didn't question what felt like a normal existence.

Even for those women who are aware of a possible pattern, the initial tendency is not to pay attention to the cyclicity.

> The way that I didn't make the connection was that I refused to dwell on what was happening to me during what I later learned was the premenstrual time, outside of that time. I just didn't want to give into feeling sick.

At the time of the conversations, all of the women are very much aware of their experience as being cyclical and menstrually determined. For all, knowledge of a cyclical pattern begins with the awareness of a pattern of physical changes. They describe the following changes: breast pain, bloating, pain, nausea, hot flushes, sensitivity to stimulants, weight gain, edema, and fatigue. Three of the women are so attuned to their physical bodies that they know exactly when they ovulate. "Yea, I can really tell when this whole thing is going to start; I know when I ovulate because I get this funny pain right where my ovaries and tubes are."

The 'PMS' Label

It is the cyclical reoccurrence of physical changes that later led all but two women to use the label of 'PMS' to define their experience. Four women are comfortable with describing their experience as 'PMS'. They relate that finally having some way of defining what is happening to them, is part of their healing and empowerment.

> I felt so much better when I realized that there was a word for what I was going through, then I felt that I could go to the Doctor and say I have 'PMS,' now what can you give me or tell me to do.
>
> Finally I had a name, then when I had to talk to somebody about it, I knew what to call it and they knew what I was talking about.

One woman dislikes using labels of any kind. Another says

> I don't want to label myself as 'having 'PMS.' I have really been reluctant to do that because the problems that I was having were mostly at the beginning of menstruation.

From our conversations, it appears that recognition of a cyclical pattern of emotional changes comes later. The emotional changes vary widely. However, emotional changes common to the women are: depression, "crying," "fogginess," "anger," and "rage." Also described are: the inability to concentrate, think clearly, and to be around other people. Anxiety and emotional lethargy also occur. The range and depth of intensity is broad.

> I find that is the only time that I feel a little depressed. I get so depressed, I'm afraid I might do something to myself.

Predictability / Unpredictability

For five women, one factor intensifying the difficulty of their experience is unpredictability: neither the onset of menstruation nor length of cycle can be predicted. They describe menstrual cycles varying from 21 days to 42 days. For these women, the onset of menstruation following ovulation varies anywhere from 3 days to 18 days. They describe how it is difficult for them to predict how they may feel premenstrually, both physically and emotionally because "every cycle is different."

> Some months I have almost no symptoms and other ones I just want to die. I look forward to a cycle where I experience severe breast pain, because that means that for that cycle I won't feel like I am on an emotional rollercoaster.

One woman describes feeling very lucky because of the predictability of her menstrual cycle.

> Yea, I have it easier than most in some ways, because I menstruate every 25 days like clockwork and feel the same during each premenstrual time--terrible--which is both good and bad because I know how I will feel, but I know that I will feel terrible.

Dreading the Premenstrum

Predictable or unpredictable, the premenstrum is still dreaded. For all, the time following ovulation is fraught with pain, either emotional, physical or both. "I begin to dread and feel frightened as soon as I know that I am ovulating, because I know it will be a nightmare for me."

The onset of menstruation brings totally different feelings, which are in sharp contrast to their premenstrual experiences.

> Premenstrually, I am really an ugly person, I ruin everything I touch, but then just in a matter of minutes as I begin to menstruate, I feel like my old self again. I can't believe the difference, on the second day of menstruation, I suddenly feel like I can handle my life again.

All of the women talk about looking forward to the beginning of menstruation. It signals relief and brief respite

CANADIAN THESES

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from what they describe as "terrifying changes." They talk about their knowledge that for at least a few days, they will feel "normal." "Suddenly I can be the person I am."

One of the most upsetting aspects of their 'PMS' experience is that the premenstrum is the only time they experience intense emotions.

> During 'PMS,' I do things like yell at my kids, and husband, and at other times I cry uncontrollably and those are things I never do at other times. I say things that I would never say otherwise, I don't know where they come from.

The intensity of the experience is a serious concern. In addition the women experience unfamiliar emotions that frighten them. "I can't believe that I am really that terrible person, who would say those kind of things."

Metaphors

Two women use metaphors to describe their experience of premenstrual change: one likens the changes to a black cloud which covers her, and the other to climbing a mountain.

> My premenstrual experience felt like a black cloud that came down on top of me, surrounding me. It would come down slowly and would begin at my forehead. I am aware of the cloud as it moves downward. At the onset of menstruation, usually when I get up in the morning, I am aware of the lifting of the black cloud and it is such an incredible change as the black cloud moves off.

> I feel like my life since I started having these problems has been like scaling up one side of a mountain, only to find myself falling down the other.

Responding to the Experience

Over the course of their experiences, the women make many attempts at surviving with integrity. Responding to their menstrual cycle changes centers around three ways of coping. One group of coping mechanisms is designed to ensure time for self (alone time). A second group involves attempts to ensure that others are kept unaware of what the woman is experiencing. The third is designed to eliminate symptoms. Other ways of responding are: going to bed, searching for a cause, seeking professional help, and disassociating from the body. All of the ways of responding produce feelings of ambivalence.

> I felt like I had to go to bed when I was premenstrual, I felt like I deserved to do that, but I felt really guilty for being that weak.

Relating

Various ways of relating to others during the premenstrual phase are described. Predominant ways are limiting or withdrawing from social contacts. Withdrawing seems to serve two important purposes: to ensure time alone and to ensure that others remain unaware. Thus withdrawing serves a protective function. All of the women feel that if others know what they think and feel during the premenstrum, then they will be rejected. In addition, withdrawing prevents others from seeing behaviour that the women perceive as destructive.

One way of preventing others from knowing, is to attempt to plan both work and personal commitments around the menstrual cycle. Work activities are programmed in such a way as to "prevent making mistakes," or "taking time off work" during this time. Important work activities were planned for times other than the premenstrual one.

> I have to plan my schedule so that the hardest and most important work is done immediately following menstruation. I do other things at work when my 'PMS' is bad. I have to be very careful how I plan my work activities, because I really screw up premenstrually--I can't think, I'm in a fog and I forget details. I just can't work when I am premenstrual.

Personal lives and commitments are also planned around the menstrual cycle in order to prevent having to attend important social functions during the premenstrual time.

> It is really important for me to schedule my social contacts so that I am not with people when I am premenstrual. I tried to juggle my whole life around my menstrual cycle and I have to plan everything, even things like going to a barbecue. I just don't accept personal engagements when I am premenstrual.

Planning becomes difficult because, for most of the women, the cycle is unpredictable.

> It is really hard to try to schedule your life, and try to juggle things, when I really can't pinpoint my menstruation down. And so I end up hardly doing anything all month, except for those few days of menstruation and a few days following. It seems like I have to live my whole life, doing everything that is important, during about 6 days out of the month.

Trying to anticipate both the onset of the premenstrual phase and how one will be feeling is another attempt to ensure that others remain unaware. Trying to predict the often unpredictable becomes a paralyzing trap.

> If I was anticipating being premenstrual at the end of the week, I would anticipate falling apart; I knew I would fall apart and so I would try to shut myself off for a few days before to prepare.

Part of the paralysis evolves from living out a self-fulfilling prophecy. "I would always worry about what would happen premenstrually, that led to dreading the time and I believe that dreading it led to it happening and made things worse." In addition, four of the six women talk about how anticipating and planning take a great deal of energy and little time and energy are left for enjoying their "good phase." "I am so busy working 18 hours a day during the 8 days that I feel well, that I can't even relax then."

Holding back in social interactions is another way of preventing others knowing. "I always take control by holding back, because holding back what I say and feel leads to self protection because if others knew or saw what I was really like, they would commit me." The women universally described incidents of not being able to hold back and described disastrous consequences. Here again a paralyzing trap--trying desperately to keep silent during the time when one is so aware of internal feelings that silence is almost impossible.

> The problem is that premenstrually I can't hold back the way I usually do and I do things that I would never dream of doing. What I have said and done has cost me important friendships and I have never gotten over that.

Holding back seems to be possible in work contexts, but not within more intimate relationships. "Oh yea, it's easy at work; I just bite my tongue and don't say anything, but when I get home I rage at everyone who is close to me and I say really hurtful things."

Hiding what one feels and hiding oneself is another way of holding back and protecting the self from exposure.

> I was always having to make excuses for what I needed to do. I would pretend an air of health and control so

> that I could hide the ugly things I was feeling. I would never tell anyone that I was feeling terrible, I just would not admit that to anyone. I used to be able to keep it really well covered up.

As described earlier, the various ways of withdrawing from social contact have an additional purpose: ensuring time alone, away from others. Usually the women are aware of needing time alone only during the premenstrual phase of their cycle.

> I began to learn that I needed time alone, all by myself, no one else around. I felt like I was totally inside myself, and I didn't want anyone to interfere with that--it was my time. I often just unplug the phone and seclude myself in the house for a few days - I don't want to talk with anyone. I just feel like I am going to go off the deep end if I can't be alone. I really like being around people, it doesn't make any sense.

People close to the women--partners, family and close friends--respond with frustration, confusion, hurt and anger, to their need for alone time.

> My friends just don't accept that I don't want to be with them premenstrually and I have lost many good friends over it.
>
> My husband left, because he just couldn't realize that I wasn't trying to hurt him by needing to be alone. My family is angry when I avoid get togethers, they grill me and are really critical of me.

Disassociating from one's body is another response to the 'PMS' experience. This is an important way of surviving for three women. Disassociation varies from blocking out physical experience to becoming so focused on extrinsics, that one's own experience is not a reality.

> I would just block out of my body; I found lots of ways to totally disassociate from my experience premenstrually and I do it in lots of ways from gardening to housecleaning.

Searching for a Cause and Blaming Self

Searching for what causes the premenstrual experience and blaming the self are two important ways of trying to understand the experience and to take control of it. Blame is sometimes directed towards the self, and at other times towards external factors (situations, other people).

Searching for possible causes leads the women to investigate many aspects of their lives. This ranges from diet and lifestyle, to mother-daughter relationships, and to anger. Each possibility is viewed as a potential cause.

> I looked for all the things I needed to be doing, maybe there was something in my life that I needed to do differently or to do. I explored the mother-daughter relationship, reading things like My Mother Myself because I thought that this could be my problem and I wondered if there was some sort of interaction there between my mother and I that had something to do with this. I began to believe that my anger was the cause of the problem, and that I needed to control it more. Maybe it was just because I was so stressed out.

Desperately searching for causes for their 'PMS' experience leads all of the women to blame both others and themselves. "I looked at the external factors to see what was causing me to feel this way." "I blamed the external things for what was happening internally."

The most common response, however, is to turn blame inside on the self. At some time during their growing-up years, the women learn to become very self-critical. Often because no other explanation can be found, they blame themselves for what is happening. The self then becomes responsible for any perceived failure in their lives.

> I blamed myself for ruining a fabulous relationship with Y, and I asked myself over and over 'what is it about me that is wrong and terrible?' It was my 'PMS' that has ruined my life. Maybe it was my fault that I felt this way, maybe I need to learn to be more creative and learn to draw or something. I really think I have done this to myself. I keep trying to feel different, but there must be something wrong with me that I can't. I know that I should be able to do what other women do, but I just can't figure out what is wrong with me.

The process of blaming the self for being 'not good enough' is directly related to what the women believe about themselves, and the extent to which they all speak of being critical of themselves. Labels such as "weak," "wimpy," "moody," "neurotic," "angry person," "crazy," and "dangerous" are used extensively in their descriptions of themselves.

Seeking Expert Help to Eliminate the Symptoms

Seeking Medical Help

Five of the six women began their journey into the medical world by consulting with their family physicians. Of these, three also consulted with gynecologists. One of the five consulted a psychiatrist on the basis of a referral from her family physician. All consulted physicians with the expectation of receiving answers and solutions. The five women sought medical help to "get something" or be "told to do something" that would stop the 'symptoms.' They were given varying forms of advice ranging from eliminating salt, sugar, and caffeine from diets to reducing stress. Prescriptions included B-12 shots, birth control pills, diuretics, thyroid pills, and valium. In addition one woman's gynecologist promised her that the only way the symptoms would stop would be to "clean her out" and perform a hysterectomy.

All of the women seeking medical intervention state that they were feeling desperate by the time they actually told a physician about their premenstrual experience.

> I waited until I was at the end of my rope before I told him; I just couldn't do anything to make a difference and I couldn't go on. I just wanted him to give me something to take this away, to make it stop. I almost didn't care what the treatment was, nothing could be worse than what I was facing every 25 days.

Regardless of the gender of the physician, the outcome and responses were consistent. The women's descriptions of their premenstrual experiences are minimized, not heard, or denied. Each woman comes away from these consultations frustrated, angry, disillusioned or more desperate. Two of the women describe feeling that the physician listened to their story because they were given prescriptions. Nonetheless, they believe that the medications prescribed were not appropriate.

> He took blood tests and told me that there was nothing wrong with me. The physician denied my experience that changing my diet made a difference. He said that nothing in my diet would make any difference. Even the holistic physician would not talk with me about my 'PMS.' I was shocked and disappointed in the whole denial and avoidance about what I was trying to say about my 'PMS' experience. I didn't get satisfying answers even to straight questions. I knew that he had not given me the information that I needed and that I knew was available. My skepticism about the medical profession was confirmed and I should have stayed away from them. I was angry because he had never explained the side-effects to me.

Seeking Alternative Health Care

Only one woman extended her journey to seek expert help into the realm of alternative healing. This journey lead her to gather information from health food stores about vitamins, to become involved with yoga and to attend an ashram, to explore dream work, and to work with a nutritionist. Nonetheless, this work did not stop the painful 'symptoms' of her 'PMS.'

Seeking Psychological Help

Five of the six women describe their experiences with psychologists, involving individual and/or couple therapy. Although directly stated by only one woman, it is also implied by the other four that it is important for them to be supported and treated as having a medical problem, not a psychological or psychiatric problem. This, in part, explains why seeking help from psychological professionals is viewed as a last resort.

> My male gynecologist referred me to a psychologist, but there was no need for me to see someone like that, because this was a physical thing; it is my body that is experiencing this, not my head. I was really angry when he suggested this, and that there was probably a psychological link, and I just kept insisting that it was a physical thing. There was nothing psychological about it.

Despite the differing therapies utilized by the psychologists involved, the focus is similar: resolve the deficiencies of the women, as perceived by the psychologists. Both male and female psychologists were sought, and the responses appeared to be similar, regardless of gender. Two of the women attempted to seek couple therapy and were both quickly told that this is not a relationship problem, but an individual one for which the women were responsible. As is the case with the medical professionals, the five women feel worse and more hopeless following psychological consultation.

> The doctor (male) wouldn't deal with the fact that I thought I was going crazy. He denied my reality of 'PMS.'
>
> She (the psychologist) discounted and de-emphasized my feelings of rage and craziness. She confirmed that this was my problem. She told my husband he was a nice guy and that he did not have to come again. I felt like a shattered wreck after 4 sessions and trapped into believing what she believed about that I was not comfortable being a woman. She also invalidated my intuition. I felt disillusioned again, because once again an expert could not help me or make any difference.

Trying to Make Changes

By reading and consulting medical and psychological professionals, all of the women attempted, and are still attempting to make changes in their lives. Changes in diet, physical activity and lifestyle are attempted. Some women attempt to eliminate or reduce those factors which they understand to be contributing to their experience. For example, five of the six women try to eliminate caffeine and/or sugar from their diets.

Another woman begins to implement yoga into her daily life, and tries and abandons colour draping as a way to give expression to her creativity. Yet another woman integrates praying into her daily routine. While some of these changes are of assistance, they do not stop the pain of the premenstrual experiences.

All of the women, except one, try to address concerns about their marriage relationships. However, only three of them state that changes in their intimate relationships make some difference. Male partners suggest that the women do the following: engage in more strenuous exercise, be more strict about dietary intake, "just be nicer," "don't get angry at everybody," "don't take everything out on me, just keep it to yourself," and "just get control of yourself, just tell yourself to smarten up."

Despite the attempts of male partners to be helpful, and despite the sincere attempts of the women to implement the advice, this adds more stress to their premenstrual experience. Many of the women quote their male partners as saying "I'll do anything I can to help you feel better." The men try and the women try; the combined result is more desperate trying at the very time of the month when the women already feel overburdened in their attempts to try harder.

> I kept trying harder to accept my husband's solution of just trying to be nicer, trying to smile more. I felt like I was walking on quicksand and binging on making so many different changes.

The purpose of making changes and of seeking professional help, for all the women, is to regain control of their behaviour and their emotions. All describe themselves as being very much 'in control' of their lives during menstruation, and subsequent to experiencing their premenstrum.

Attempts to regain control are intricately linked to the hope that if everything is done 'right,' the problems will be eliminated. 'Right' means what others (usually professionals) tell them to do.

> ... and then I would think that if I could just get it

> all together this month, and get this thing under control, get control over myself, just do it right, then I will be ok. I hope that this month I can do all of these things all of the time, and then next month couldn't possibly be as bad. See I had this expectation that if I do everything right this month, do all the right things, then I can change this experience.

Feeling the Impact of the 'PMS' Experience - Not Trusting Self

The impact of their premenstrual experiences includes the following consequence for the women: being different, further evidence for not trusting self, needing to hide the self because of shame, self labelling, and feeling crazy.

Five of the women describe a pattern of not being able to trust themselves to do or say the right thing. The other woman does not speak of this as an issue for her. The five women's premenstrual experience confirms for them that the self can not be trusted.

> I couldn't go anywhere, because I never know what terrible thing I might say or do, or how I might react. I used to think that I could not be trusted, now I know that I can't be. Now I believe that I really do have destructive motivations.

The women undergo a similar process in being convinced that the premenstrual experience confirms that they are, in fact, different in ways that are not acceptable. "I don't know anybody who feels as I do, and no one wants to be around me anymore." As a direct consequence of not trusting and feeling different, the 'PMS' experience leaves the women feeling that they must hide themselves in more elaborate ways because of being ashamed of themselves. "I think that I have to lock myself up more than I used to because I am so ashamed of what I can do to people during my 'PMS.'"

Feeling Crazy

Feeling crazy is a theme in all of the women's stories. The degree of craziness they experience varies. The reasons for, and the consequences of, feeling crazy are unique and are described in different words, but the essence remains: being misunderstood by others, feeling crazy inside, and feeling hopeless and suicidal. Tragically, the helping professionals confirmto them, either explicitly or implicitly, that the women are crazy.

Feeling crazy inside. All of the women describe their 'PMS' experience as proof that they are, in fact, crazy. How each woman comes to this assessment of herself is different. The following terms are used to describe the experience of craziness: "Dr. Jekyll and Mr Hyde," "two different people," "I have a split personality," or "having this nutso person inside." For others the descriptors are "like an ugly monster," "a raging maniac" and "dipping off the deep end." The women offer further descriptions by saying:

> I began to feel like a wreck on the inside and still performed like I was ok outside. I hated my body for doing this terrible thing to me and I hate myself. I felt really scared because this experience is changing my thought patterns, I don't know who I am anymore. I must be crazy because I blow up at others; I would just dip off and get spinning in the wrong direction, get really depressed and not get a grip on things.

Two additional factors that contribute to feeling crazy are experiencing emotions as out of control and feeling misunderstood by others. For example, all the women talk about crying for no apparent reason, and how it felt to be out of control. "I would cry and burst into tears so suddenly, it was embarrassing because I couldn't even tell what I was crying for."

Feeling intense anger. Accompanying feelings of intense sadness are feelings of intense anger, which often become rage. "My anger is really frightening because it becomes uncontrollable rage." "I feel absolutely angry, in a rage at my whole living situation and my whole life." Their experience of anger is another factor which keeps isolating them from others. "How could I possibly share that I was this angry, raging person? I had to hide it."

As with sadness, they are unable to understand the source of their anger. They describe "blowing up" at things that "don't matter." All of the women describing this experience are frightened by both the intensity and possible consequences of their anger, particularly because anger is only expressed at family members.

> I could never predict what I might do when I was angry. One time I threw a high chair (without the baby) across the room. I am frightened about what I could be capable of.

Some of the women come to the conclusion that 'their anger' is the problem which needs to be fixed and stopped.

> I began to see anger as the problem, what I needed to do was to control it. I tried everything to get rid of my anger, because I thought it was the problem. I blamed what was happening to me on my anger. I tried physical exercise to get rid of it, then I went to therapy to focus on my anger.

Support from others for feeling crazy. All of the women who have experienced contact with medical or psychological professionals describe the professionals as making comments which confirmed their own beliefs of craziness.

> When we went for couple counselling, the therapist told my husband that she didn't want to see him again that there was nothing wrong with him; I felt like I was really crazy then. When the doctor referred me to a psychiatrist, that confirmed for me I was crazy.

Additional confirmation is provided by friends, intimate partners and family members.

> Friends and family thought I was crazy and planned things for when I was in my right mind, and they told me that. My father always tells me I am crazy and has for as long as I can remember. Now he tells me that what I do just confirms that.

For one woman, even her choice of career validates this feeling.

> I was planning to be a psychologist and you know all the stories about how only crazy people are psychologists, that psychologists are those who have lots of their own problems and that's why they become psychologists so they can sort out their own lives.

The women also share some thoughts about what happens when you feel like you are crazy. "Going crazy really gets you, because you have no idea what is going to happen next, or what you will say or do."

Feeling Helpless and Hopeless

Feelings of helplessness and hopelessness are described by all of the women except one. The woman who does not describe these feelings was in the early stages of her 'PMS' experience at the time of the conversations. One aspect of feeling hopeless is feeling misunderstood.

> I am feeling hopeless and helpless, I can't see any solution. I can't make any sense of this, my 'PMS' has ruined my marriage, and taken over my life. Reading the research has lead me to feel hopeless, nobody seems to know what to do, even the experts.

The women's behaviour is interpreted as meaning things the women neither intend nor feel. Not being taken seriously for what they try to say is a problem.

> My husband believed that I took this out on everyone intentionally. Even when I was feeling totally incapable and alone and I told them that, my family thought I could take care of myself, and that I didn't need their help. Even when I saw the psychologist, and tried to describe what was happening to me, he didn't take me seriously.

Feeling crazy, having others confirm their craziness, and feeling hopeless, led two of the women to consider suicide as the only solution left. This was a desperate move to end their pain, as no other solution seemed possible. Neither of the two women made an actual suicidal attempt.

> I felt like the only way out was to die, because how else could I stop what was happening to me. I had tried everything I and everybody else knew and nothing made a difference.

Impact on Others

All of the women talk extensively during our conversations about how concerned they are about the effect of their 'PMS' on those close to them. In spite of feeling desperate and even suicidal, focus is often on "look how this is hurting those I love."

The response of their partners is very important to the women. At times they describe, with understanding and compassion, their partner's pain about their 'PMS.' At other times they are confused and angered by the responses.

> He just wants me to feel better. It is really difficult for him to watch me go through this. He wants sameness all the time, not my moodiness. He just thinks that I am just this way, no hope for change.

In addition, they describe how their 'PMS' experience has pulled themselves and their partners apart.

> He just can't understand and won't talk about it. Talking just led to frustration and hurt for both of us. He left me because of this experience, I guess he just couldn't handle it and I'm not surprised, I would leave my self if I could.

The women also express concern about how this experience is affecting their children. "I am really worried about what I am doing to my children, I know sometimes they are frightened of me."

The 'Symptoms' Become Worse

All of the women describe the worsening of their 'symptoms.' One woman relates that the symptoms intensify as she becomes older. Another women describes the whole process as totally confusing for her. "When I began to pay attention and try to deal with this problem, it started getting worse instead of better." As the women consult professionals they experience the same phenomenon. "While seeing all these experts, my feelings escalated, my moodiness intensified, and 'PMS' trouble doubled." It is, in part, the escalation of the pain of the experience which leads some of the women to hopelessness and thoughts of suicide.

Healing

Talking with Other Women

Seeking healing both from and with other women begins with a recognition of needing understanding from others and from realizing the need to talk with other women. Subsequently, networking begins to take place in women's groups--women's support groups and 'PMS' support groups. "I realized that I need understanding from others on a regular basis; I need someone that I can share with." All of the women describe times of trying to share this experience with their partners, but do not find this to be satisfying: "I thought he could talk with me about it, but he couldn't." "I thought he would understand but he just couldn't relate; he had nothing in his experience to draw on."

Four women begin this sharing with individual friends. One women states that she has started to choose friends whose life experience or ideas are more similar to her own. One woman discovers that she values her friend's sharing so intensely that she feels she had lost her whole support system when the friend leaves.

> I finally talked with my neighbor and began to understand her experience with 'PMS.' I began to not feel so alone. I found out that other women isolated themselves even more than I did.

One woman states that the most important aspect of this sharing with a friend is "really being listened to by another woman and it was such a wonderful experience." It was such a relief to have her confirm my own experience." This time of personal one-to-one sharing is the beginning of 'breaking the silence.'

Important sharing and healing also take place for those women who participate in either women's 'PMS' support groups, or women's general support groups. Four women participate in some type of group interaction. They discover, often for the first time, that they are not alone in their experience: the experience of others is both similar and different (some only headaches, others suicidal). Important information is provided in the groups: they are not really going crazy, or if they are--so are most of the other women. The women say that they learn new and useful things to try for themselves. Important information that is not available is shared through other women's life experience.

> I learned that other women were falling apart too. I just couldn't believe it; they felt the same way that I did. This was the hardest thing for me to imagine: it was hard for me to believe that other women believed they were crazy too.
>
> After the initial just looking at each other, everyone shared what they could, information and experience. I just couldn't believe that women really shared like this: everyone told their story.
>
> I found out that there are so many women out there with similar experiences, that there are clinics just for this.

For one of the women, this experience of woman-sharing is so important that she begins to facilitate other women's groups. For her this is an "important part of my therapy." Another woman finds herself speaking out publicly about her 'PMS' experience--something she would never have done before. For these two women, the 'PMS' label is important because they believe it enables them to share their experience with others.

Women's groups are important for many reasons. Most importantly, as stated by these two women, is that "going public" and helping others is part of their process of coming to value themselves. "I realized that I did value myself when I believed that I could maybe help others with this experience."

Seeking Help

The ways of seeking help during the healing process are qualitatively different from those of seeking help during the times of feeling desperate. Although women often read similar books and articles on 'PMS' during both times, the lens through which they are read is different. During the healing phase, information is taken in and personally evaluated as to how it fits the individual's needs. "I didn't just do everything everyone told me to do; I thought about whether it fit for me." The key, as the women describe, is seeking self-help. Self-help in this context does not mean doing it all alone. Instead, the women view the professionals they work with, and the literature they read, as 'partners' in their own healing process.

Working With a Feminist Therapist

For three of the women, having a therapeutic relationship with a feminist therapist is a pivotal point in their healing. One woman has worked with a feminist therapist who has experience of her own healing in regards to 'PMS.' These women describe being "empowered," "supported," "valued," and "helped in their struggle to define themselves," by the feminist therapists.

> The feminist therapist helped me change my life. She really changed my view of things, confirmed my

> strengths and helped me do what I needed to do to be myself. She helped me to believe that I had what it takes to make a difference for myself. She supported me in my ability to make choices for myself, to deal with some issues now and leave others until later.

One of the differences that the women describe about the feminist therapists, is that the woman, not the therapist, determines the course of the healing journey. "I told her what I wanted to deal with, not the other way around and that was so different than the other therapists I had seen." Another important difference described is that the feminist therapists help the women to consider the context of their experience: to understand women's experience in light of their cultural context, and the implications of such.

> For me the thing that made the most difference was hearing and reading that much of my experience is related to what is expected of women and how they are treated in this society.

In addition, contact with Feminism, through reading, therapy, workshops, or talking with other women, brings the women to come to the understanding that most of the problem is connected to how women are locked into roles and behaviors that are assigned to them.

> I finally began to realize that I didn't have to do or be what I thought I had to. I realized that I had not known what I was or who I was. I had been so busy trying to do what I thought I should be doing or saying, that I never stopped to ask myself,--what is it that you really want to say or do?

For one woman, another professional has been helpful in her healing, a male gynecologist. She had contacted numerous medical professionals and had been very "shattered" by her contact with them. This experience has been different, partly as she describes, because she is different and partly because

> he is different; I don't know how he survives in the medical community.... I couldn't believe it! He genuinely listened to me and was interested in my experience. He didn't preach to me and had read the current literature and the self-help stuff. He just amazed me, listening and acknowledging my experience.

The Impact

Paying Attention to Self: Learning and Discovering

Shifting into healing is, in essence, the shift towards paying attention to self, defining the self, and valuing of self. Becoming aware, accepting of self and subsequently changing beliefs are described.

The women who are in the process of healing relate that many of their basic beliefs about themselves, about their relationships, and about their 'PMS' experience are changing drastically. For example, they are beginning to believe that others are equally responsible for the quality of a relationship. They also believe that they have the right to do what is best for themselves. In addition, they are beginning to view their 'PMS' experience as valuable and positive.

> I learned to use my cycle because I am more intuitive premenstrually, and am more aware of my self. I like going inside now and use my premenstrual time as a time of permission to be different. Now I view my 'PMS' experience as having helped me to decide who I am, and to know more parts of myself. My 'PMS' experience has forced me to look at my life, re-assess parts, and make major changes, but it took me three years to view this as positive.

The women describe, as critical to healing, their increased self-awareness and self-acceptance. They relate numerous changes.

They realize that they can experience all aspects of their personalities without blame, because the good / bad dichotomy is no longer so distinct. They value their ability to express anger. They respect the messages given to them by their bodies. They become aware of changes that need to be made. They believe that they have the right to say "enough already." They see the relationship of healing and connecting, to what used to be opposites (i.e., anger and love).

> I know that I am a woman who deserves time to herself and I am not willing any more to give up any parts of myself because of meeting someone else's needs. I value my parts.
>
> I am beginning to accept who I am and am beginning to value my 'terrific moods' and the anger and you know what, I have discovered that it is really exciting to explore myself.
>
> I am learning to let go of what everyone taught me to be, and to stop saying yes to everything.
>
> I realize that I need to keep changing what I do for myself, as some cycles I need different things.

The Goddess and St. Valentine

... My body is puffed and sore.
I bled and ache and I am happy
I lay curled in bed
waiting out the pain.
I cannot eat. I break out in sweat
There are drugs I can take for this
but I don't.
I want to feel this swollen day
and contemplate
the power of the moon.

Patricia Handrich (cited in Taylor, 1988, p. 33)

5. A BRIEF OVERVIEW OF THE THEORY

The women have told their story. Now it is time to map a theory that explains their pain and that illuminates the journey they maDe. This chapter provides a brief overview of the theory via the utilization of a metaphor. The metaphor compares the "coding families" (Glaser, 1978, p.74) employed in Grounded Theory research to a roadmap. These coding families consist of context, conditions, turning point, strategies, and consequences. (These are explained within this overview.)

This chapter offers a brief outline or written chart as a guide to chapter 6. The detailed explanation required is provided within chapter 6, and it is there that the move from the description provided in the story to the explanation of a pattern of behaviors--the theory--is found. Chapter 7 is provided as an extension of the theory, and discusses the realm of Healing. It describes healing as it was experienced by some of the women who shared their story.

In Grounded Theory research it is necessary to begin with the context of the theory: for the women whose story is told here, the context is the terrain they enter as they are birthed. It is like the paper on which the map is written. The paper symbolizes the actual geographic terrain. The context of these women's lives is the culture where they acquire their life experiences. The particular patterns of their lives are the individual roads they travel, but nonetheless, all the roads are built upon the same cultural context. The terrain is composed of the following:

1. culturally acquired beliefs about the feminine role;
2. culturally acquired beliefs about nurturing;
3. culturally acquired beliefs about anger;
4. culturally acquired beliefs about the need to prohibit anger in order to maintain and nurture relationships; and
5. culturally acquired beliefs about the necessity of hiding in order to avoid alienation.

The conditions are the particular geographic landmarks--mountains, valleys, rivers, deserts and villages--of the terrain travelled. The women whose journey is recorded on this map encounter four significant landmarks:

1. Being a female child in a Western culture;
2. being a child of dysfunctional family background; and
3. experiencing a negative introduction to menstruation;

These particular women all pass through these landmarks. Just as the construction of a highway is affected by the physical features of the land through which it passes, the women's lives are shaped by these conditions.

If the context is the terrain, if the conditions are the landmarks, and if the journey is the roadway, then the women's 'PMS' experience is the roadblock--an impasse in their lives. In the language of Grounded Theory, this is the Turning Point; the impasse of severe premenstrual change forces the women off the roadway, into a desperate search for a way around this roadblock.

This search leads them through an exhausting series of detours. The detours, or strategies, are the remedies the women employ in the attempt to ameliorate their premenstrual experience. These strategies are:

a. denying
b. hiding
c. normalizing
d. comparing self to others--choosing relationships as adults
e. anticipating
f. seeking expert help
g. attributing
h. hoping
i. holding back and letting go
j. isolating self.

Tragically, these detours lead only to a dead end: the experience of severe premenstrual change remains as an omnipresent obstacle.

When the strategies, or detours, fail, the women confront a situation analogous to that of a driver who, exhausted by an interminable search around an impassable roadblock, loses control of the vehicle and plunges off the road altogether. The women in this story plunge off the road and spiral into a void. Having expended almost superhuman energy to surmount the impasse, they feel the terrible rage produced by ultimate failure. The consequences of this are:

1. spiralling of rage leading to belief in craziness
2. remaining trapped
3. exposing the fiction of ideal womanhood (this only applies to the women who are in the process of healing.)

Figures 4 and 5 have been included to assist the reader in the process of following the women's journey. As described above, the Theory of Premenstrual Pain begins in a cultural terrain that retains patriarchal vestiges.

Soon after birth, women begin the process of 'losing access to the primary self' (sub-Basic Psychological Process--sub-BPP). Occurring simultaneously, women are given something to replace the 'primary self'--the self of 'ideal womanhood' or the 'secondary self.' The 'secondary self' is a self that reflects the values, attitudes, standards, and beliefs of a patriarchal culture. As they journey, these women 'lose access to the primary self,' and identify more and more with the imposed self of 'ideal womanhood.'

Many of the lessons taught to young girls and women intensify this process (the Context and the Conditions). During this time, the related experiences of 'trying to be the ideal woman' and 'failing to be the ideal woman,' are becoming interwoven. These repeated experiences can best be described in terms of a negative feedback loop. A negative feedback loop is appropriate because the harder the women try to be 'ideal women,' the more they perceive themselves as failing; the more they fail, the harder they try. During their childhood, these women begin to develop strategies designed to enable them to be successful as 'ideal Woman.' By the nature of the conditions they encounter on their life's journey, this particular group of women might be especially vulnerable to the most patriarchal aspects of the culture.

The onset of menstruation brings a shift in this process. It may be the first time the women experience a glimmer of the Primary Self since very early childhood. However, the patriarchal aspects of the culture that they have internalized may prevent this process of self-discovery from evolving. Furthermore, the particular conditions of their childhood may exacerbate their difficulty regarding self-discovery.

As adults, the women experience what is commonly referred to as 'PMS.' The premenstrual experience is the Turning Point of this theory. Until the women are free to get off the highway of 'ideal womanhood,' they view their premenstrual experience as a monthly reminder of their 'failing' as 'ideal woman.' During this time, 'trying' and 'failing' spiral together and lead the women into a paralyzing void, or abyss. It is a void because they have no awareness of having any access to the Primary Self; the only sense of self they can access--the Self of 'ideal womanhood'--has become completely unattainable. They believe that 'ideal womanhood' is unattainable because of their immense failures.

What happens to them when they are plummeted into the void? There is now a circle on the roadway. Some of the women, out of their deep desperation, keep journeying around the circle, from the void back to the strategies. They have learned their lessons too well--they believe that the 'right strategy' will enable them to be successful in their assigned role of 'ideal womanhood.' For other women the possibility that there is a pathway off the roadway becomes a reality. This is the pathway that enables them to Expose the Fiction of the Ideal Woman (Core Basic Psychological Process - BPP). 'Trying' and 'failing' now collapse into one process. This leaves room for beginning to move along their own pathways toward 'healing.'

The journey of each woman as she continues in her own process of healing is unique to her. However, there appear to be some common experiences. These are:

a. connecting and breaking the silence; and

b. accessing the primary self.

Table 3

Core Basic Psychological Process (BPP) - Exposing the Fiction

Context:	The Western cultural context -culturally acquired beliefs about the feminine role; -culturally acquired beliefs about women and nurturing -culturally acquired beliefs about women and anger -culturally acquired beliefs about the necessity of hiding to avoid alienation
Conditions:	Being a female child in a Western cultural context Being a child of dysfunctional family background Experiencing a negative introduction to menstruation
Turning Point:	The Premenstrual Experience ('PMS')
Strategies:	Denying Hiding Normalizing Comparing Self to Others Seeking Expert Help Attributing Hoping Holding on and Letting Go Isolating Self
Consequences:	Spiralling of Rage Leading to Belief in Craziness Remaining Trapped Exposing the Fiction of the Ideal Woman

Figure 2. The Process of Exposing the Fiction

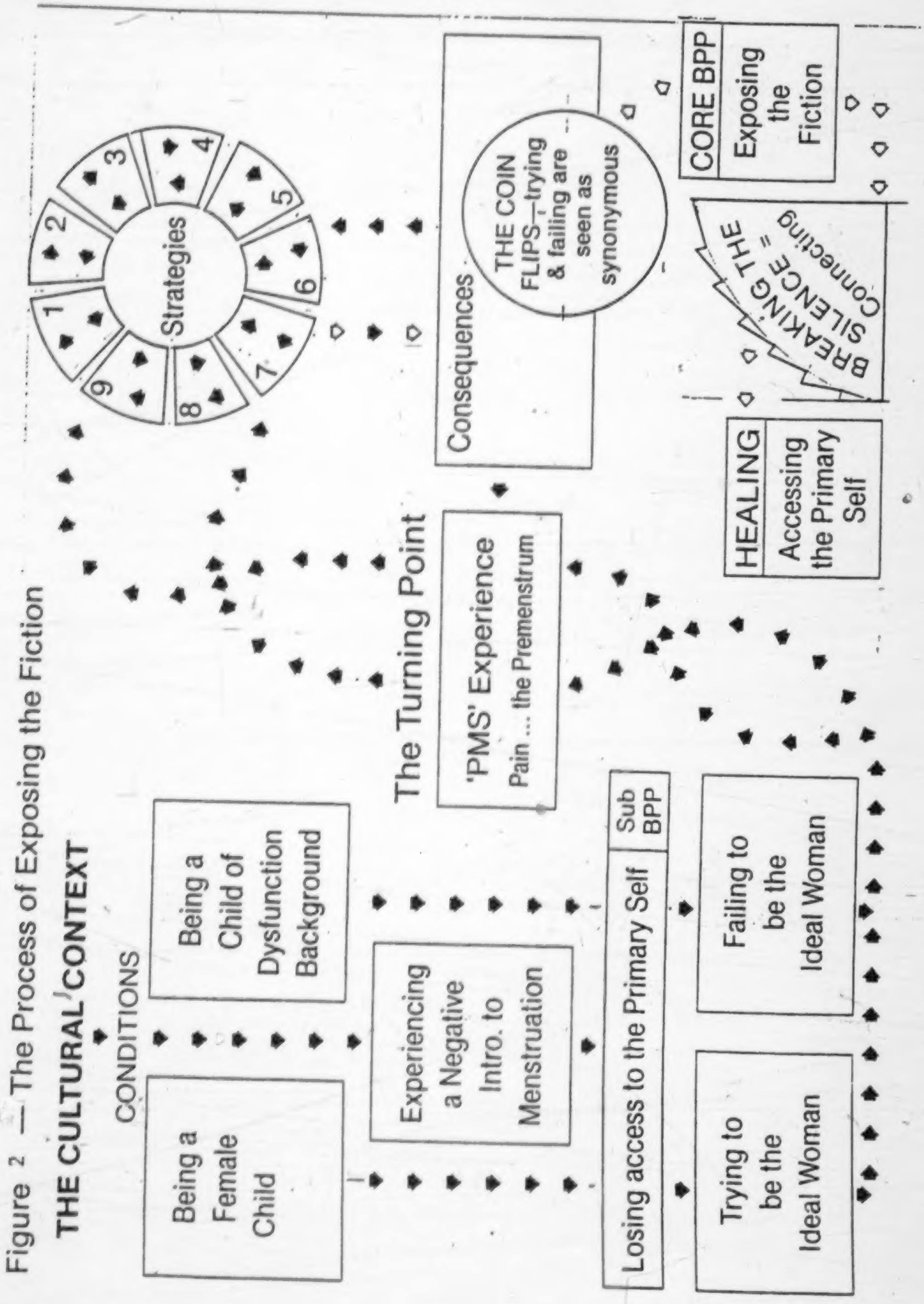
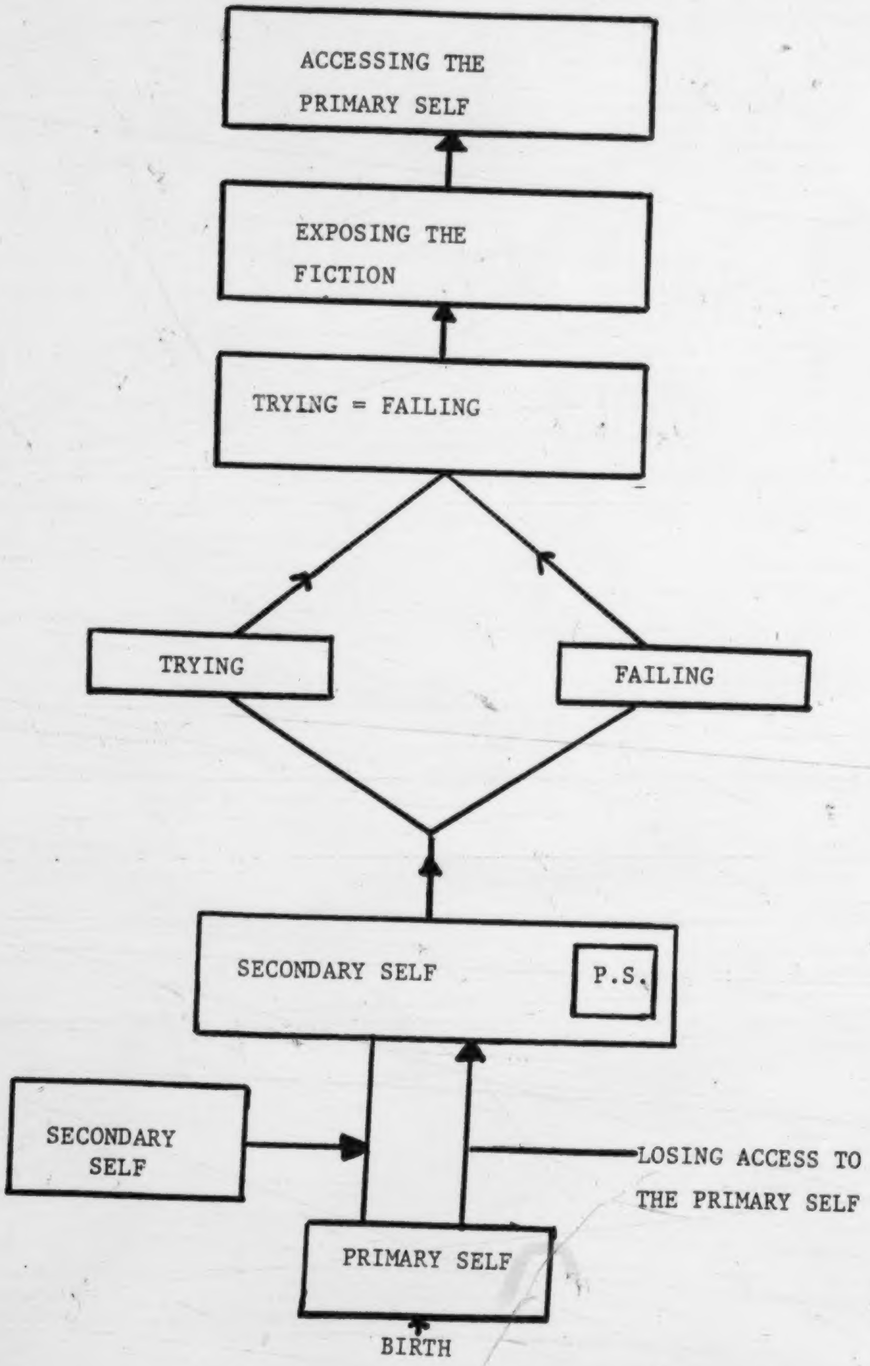


Figure 2 — The Process of Exposing the Fiction
THE CULTURAL CONTEXT
CONDITIONS
Being a Female Child
Being a Child of Dysfunction Background
Experiencing a Negative Intro. to Menstruation
Losing access to the Primary Self
Sub BPP
Trying to be the Ideal Woman
Failing to be the Ideal Woman
The Turning Point
'PMS' Experience
Pain ... the Premenstrum
Strategies
1
2
3
4
5
6
7
8
9
Consequences
THE COIN FLIPS—trying & failing are seen as synonymous
HEALING
Accessing the Primary Self
BREAKING THE SILENCE
=
Connecting
CORE BPP
Exposing the Fiction

Figure 3. Overview of Basic Psycological Processes


ACCESSING THE PRIMARY SELF
EXPOSING THE FICTION
TRYING = FAILING
TRYING
FAILING
SECONDARY SELF
P.S.
SECONDARY SELF
LOSING ACCESS TO THE PRIMARY SELF
PRIMARY SELF
BIRTH

6. A THEORY OF EXPOSING THE FICTION OF IDEAL WOMANHOOD

Context

The Patriarchal Cultural Context

Defining the Patriarchy

The terrain travelled by the women whose story is told here is the cultural context in which they have lived their lives from birth. This cultural context is patriarchal. The purpose of this thesis is not to argue the various positions currently in dispute regarding Western culture and the extent of patriarchal influence and/or domination. Such issues are better left to research that has as its focus the actual extent of patriarchal influence on current Western culture, or research that attempts to measure the changes that have occurred.

Part of the difficulty I experienced in my attempts to find adequate definitions of 'the patriarchy' may be explained by what Johnson (1987), calls "the structural re-alignment in sex roles" (p.350) when he proposes that "premenstrual syndrome can serve as a symbolic barometer of status and role changes of women in modern society." (p.351) On one hand, it may be that women's roles are changing so quickly, and consequently so is the patriarchal aspect of the culture, that there is a lack of ability on the part of linguists, anthropologists, sociologists, and other researchers to keep pace. On the other hand, it may be that the controversy as to whether or not the patriarchal influence is still as strong as ever, but has changed its overt form, becoming disguised, has shifted emphasis to argument, rather than to suitable current definitions.

Certainly, the definition found in the Random House Dictionary of the English Language hardly seems adequate:

> a form of social organization in which the father is the supreme authority in the family, clan, or tribe ... (p.1422)

Instead of contributing to the controversy about the extent of patriarchal influence in this culture (this is not to denigrate the significance of the issue), I have chosen to recognize that--rapid as some role changes may be within the fabric of a culture--the overall structure changes less rapidly. Therefore, we are still living in a patriarchal cultural context. An irony that currently confronts North American women is that although tremendous gains have been made in freeing women from traditional strictures, this has had the effect of camouflaging the power still maintained by the patriarchy, within the overall culture.

According to Ferguson (1983, cited in Luepnitz, 1988) a shift has been made from the father-patriarchy and husband-patriarchy of earlier centuries to what she calls public patriarchy. Luepnitz (1988) states that

> While under earlier forms of patriarchy it was a male person who limited the women's expenditures, freedom to work, and sexual activity, in the case of public patriarchy, it is the state, the welfare agency, and the media that control these things. Public patriarchy is both an advance and a retreat for women,. . . . Since public authority is more diffuse than personal authority, it is easier to cheat on. Being more diffuse, however, it is often harder to identify and to fight and, ultimately, the patriarchal state is more powerful than any single family. (p.17)

My intent is not to vilify men under the guise of railing against the patriarchy, but it is important to remember that the fabric of a culture changes slowly. Therefore, it is hardly surprising that despite the tremendous strides made by women and men in overcoming previous patriarchal acculturation, traditional expectations of the Western cultural context still haunt both sexes.

Participants related their confusion when they encountered this cultural context in their own lives.

> I don't understand why I feel guilty all the time. I know that I have a demanding job which pays good money, I take good care of my child, and yet I still feel bad because I am too exhausted to keep the house immaculate and make home-cooked meals. Maybe it's because my husband doesn't help unless he is asked and it seems to be what women are supposed to do.

> I guess I feel the equality thing isn't what it's cracked up to be. Some of my friends think I am a real ground-breaker because I have a job in a non-traditional field for women. But when I get to work at 9:00, I've already been up for four hours. First I dress myself, then I wake up the baby, make breakfast, get everything packed, and finally take my son to daycare. The men I work with complain about having to get up at 7:00 to beat the rush-hour traffic.

For the purposes of this study, patriarchy and patriarchal culture are used to mean the following:

> Patriarchy in its wider definition means the manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general. It implies that men hold power in all the important institutions of society and that women are deprived of access to such power. It does not imply that women are totally powerless or actually deprived of rights, influence, and resources. One of the most challenging tasks of Women's History is to trace with precision the various forms and modes in which patriarchy appears historically, the shifts and changes

> in its structure and function, and the adaptions it makes to female pressure and demands. (Lerner, 1986, p.239)

It is now time to peruse the map in detail. The women are birthed into a patriarchal cultural context. That they are born female, predetermines the roadway their life journey follows. The predestined road they travel, is the road of 'ideal womanhood,' which is the definition of what a woman should be, if she is to win approval in our cultural context. The nature of all cultures is that gender roles are predetermined for both sexes.

As a woman learns her lessons, 'ideal womanhood' becomes a 'secondary self' superimposed on the 'primary self' she brought into the world. Women are taught--almost from the moment of birth--that the only 'self' they are allowed is the 'self' that the culture deems appropriate for its female members.

The imposition of this 'secondary self' over the 'primary self' ultimately contributes to the women's Losing Access to their 'primary self.' 'Losing access to the primary self' is the sub-BPP, and is an essential component of the core Basic Psychological Process (BPP): 'exposing the fiction of ideal womanhood.' This sub-BPP is composed of a negative feedback loop: 'trying to be the ideal woman,' and 'failing to be the ideal woman.'

For the purposes of this theory, the 'primary self,' is defined as the 'self' that each human being brings into the world at the time of birth and emerges throughout the course of a lifetime. It is the potential to develop into a unique individual both emotionally and intellectually. As such, the 'primary self' is the original 'sense of being' and involves the recognition on the part of even very young infants that they are themselves and are separate in identity from others. At the stage where it can be argued that the human infant does not separate its own identity from those around it (i.e., the parents), others can nonetheless identify differences in personality and behaviour in newborn human infants.

Thus, the 'primary self' is the unique expression of its individual being brought into the world by each infant. It is also the potential to develop that self more fully according to the individual's own intrinsic characteristics.

The concepts of a 'primary' and 'secondary self' are well established in personality theory. For example, Carl Rogers describes the 'real self' and the 'pseudo self.' Rogers postulates that the split between the two (or 'self-incongruence') creates much of the distress for which individuals seek the help of psychotherapists. Rogers describes the 'pseudo self' as the self presented to the world as a result of how others respond to our behaviour. The 'pseudo self' is the result of the individual's attempt to present a self that is perceived as more acceptable within the context of the individual's environment, both at the level of the small-scale social group and the larger society.

A woman born into a patriarchal cultural context must travel a road that splits in half beneath her feet. It is as if one foot is literally planted in the world of 'trying to be the ideal woman,' and the other in the world of 'failing to be the ideal woman.' Thus, ambivalence is built into the women's lives from early childhood. Ambivalence is augmented and accelerated by the process of 'losing access to the primary self' as these women learn to superimpose the 'secondary self' over it. This is not dissimilar to the process described by Rogers in his discussion of 'self incongruence,' and the distress it creates.

Culturally Acquired Beliefs About the Feminine Role

The route by which the women 'lose access to the primary self' (sub-BPP) is the route of 'trying' and 'failing to be the ideal woman.' Why do the women follow such a roadway? For answers, it is necessary to examine the beliefs that this patriarchal culture thrusts upon them.

Traditional definitions of female roles form the basis of these women's beliefs about what they should be. Participants in the story offered a variety of statements on this theme.

> My mother said that I must learn to be a lady. Nice men don't really like women who aren't ladylike and don't marry them.
>
> I was taught that it was a woman's obligation to put her family first. Her husband's career was more important.
>
> My mother told me that ladies always sat with their legs together and crossed at the ankles. Nice women never sat with their legs apart. I remember her telling me this from the time I was very little. I resented it because my brother could sprawl any way he wanted to.
>
> Having children was something my parents said all

> normal women wanted to do. I remember they felt really sorry for one of our neighbors who couldn't have children and said nothing worse could happen to a woman.

The traditional female role is that of a subordinate: "subordinates are described in terms of, and encouraged to develop personal, psychological characteristics pleasing to the dominant group" (Miller, 1986, p.7). According to Bem's Sex Roles Inventory, the most desirable feminine qualities are:

> affectionate, cheerful, childlike, compassionate, doesn't use harsh language, eager to soothe hurt feelings, feminine, flatterable, gentle, gullible, loves children, soft spoken, sympathetic, tender, sensitive to needs of others, warm, tender, understanding, yielding. (Caplan, 1981, p.46)

These characteristics are taught to women early in childhood by mothers who "teach the lessons of the fathers" (Butler, 1988). As the lessons are learned, the 'primary self' becomes more and more difficult to access: the constant task of learning and trying to be 'The Ideal Women' leaves neither room to develop, nor time to develop the 'primary self' that the women brought into the world as part of their unique birthright.

> Sometimes I feel like I don't know who I really am because I think I spent most of my life trying to be good and do the right thing. I don't even know what colours I like, or how I would like to dress because I spent most of my time trying to fit in and please my parents, friends and the people I work with.

Culturally Acquired Beliefs About Nurturing

A strikingly powerful belief, which seems to be acquired at a very young age, is that women--in order to be good or ideal--must always be nurturing.

From very early in life, little girls are trained to be

> sensitive to other people's feelings and needs. This is a first step towards the nurturer's role ... . (Caplan, 1981, p.35,36)

Little girls learn early that affection and approval are awarded on the basis of being good, being sweet, being helpful, and being unselfish.

> My mother's favorite comment to me whenever she didn't like what I was doing, was to tell me that I was being selfish. She said that nice girls weren't like that. She told me that I was being selfish because I wanted to go back to school, because my husband needed me to support his career financially.

The women whose journey is mapped here learned this particular lesson especially well. They speak of "being nice to others," "knowing how to look after others," and being prepared to put "others ahead of themselves." Smith (1978) refers to a story that epitomizes the Ideal nurturant role.

> There was a young man who loved a maid
> Who taunted him: "Are you afraid,"
> She asked, "to bring me today
> Your mothers heart upon a tray?"
>
> He went and slew his mother dead;
> Tore from her breast her heart so red,
> Then towards his lady love he raced
> But tripped and fell in all his haste
>
> As the heart rolled on the ground
> It gave forth a plaintive sound.
> And it spoke in accents mild:
> "Did you hurt yourself, my child."
> (Cited in Smith, 1978, p.30)

Neither woman-blaming nor mother-blaming is what is being described here: the poem illustrates--albeit in a grotesque and blatant fashion--the ultimate approved behaviour for the 'ideal woman.' She is expected to sacrifice herself for others, whether they are children, friends, partners, or family. The blatant physical self-sacrifice described in the poem is perhaps less dangerous to women; because it is obvious, it can be recognized and immediately deplored. The emotional sacrifice of the self for others ('losing access to the primary self' sub-BPP's), which is the ultimate effect of the nurturing role, is far more dangerous because it is much more insidious.

'Trying' to nurture according to the culturally-imposed standard of 'ideal womanhood,' ('trying to be the ideal woman') is an impossible task: not only are women required to sacrifice themselves for others, but also they are discouraged from feeling resentment about nurturing others at the expense of self. The resentment and inevitable anger that flow from not being allowed to nurture the self, confirms for women that they are 'failing to be ideal women.'

> I hate myself when I am exhausted after a bad day at work and it's just before my period and I lose my temper and yell at the kids and threaten to hit them. A good mother wouldn't do that and I should be able to control myself and remember that they're only kids and I am an adult.

Culturally Acquired Beliefs About Anger

The inevitable anger, expressed by each of the women, is the combined result of travelling the cultural terrain, and the particular conditions they experience. Throughout their story, the women undergoing severe premenstrual changes speak consistently of anger. Their premenstrum is the physical manifestation of the sub-BPP of 'losing access to the primary self.' This occurs because the women travel through a patriarchal culture: the roadway prescribed for them is 'trying to be the ideal woman' and results in the inevitable 'failing to be the ideal woman.'

The emotion of anger has been "named and conceptualized by the social context (patriarchal system)" (Miller, 1983, p.8). Direct expression of anger is both socially and legally silenced in almost all cultures, for all members (Burtle, 1985). Thus anger has become an emotion to be repressed, denied, and feared by both males and females.

> It's not that I am really angry at my husband for not doing some of the housework, it's just that I don't really think that this is fair.

> The most terrifying thing about my 'PMS' is that I feel so angry. Sometimes I just feel like I am going to explode in rage and that scares me and everyone around me. I'm not really an angry person.

This belief may stem from anger's association with many types of dangerous behaviors.

> Our cultural structure then ascribes anger to an inherently dangerous drive--ultimately making us afraid of ourselves and unable to use our anger for a better structure. (Miller, 1983, p.8)

As anger is perceived as an "inherently dangerous drive", it's expression is viewed as deviance.

> No society can afford not to defend itself against deviance, ... not attempt to change those who oppose its rules and structure. (Watzlawick, Weakland, & Fisch, 1974, p.69)

Women are living in a context that perpetually creates feelings of anger. If the cultural context limits the expression of male anger, ideal women are not allowed to experience it at all. Thus, women are not allowed to experience what the 'primary self' feels, and this contributes to the sub-

BPP of 'losing access to the primary self.'

> The normal woman is thus perceived as socially passive in terms of acting out behaviour and passionless in her experience of an important human emotion (anger). (Burtle, 1985, p.71)

In summary, women are placed in a conflict position: living in a cultural context of patriarchal overtones produces deep feelings of anger; however, the view of the ideal woman--"the good woman," "woman as angerless" (Burtle, 1985, p.71), denies her the right to be angry ('trying to be the ideal woman').

> Everytime I get angry it seems like all the people close to me are horrified and say 'How can you behave like this'? Everything seems to be fine so long as I don't get angry. I don't understand why women can't get angry, and yet I know that I feel guilty every time I do.

Culturally Acquired Beliefs About the Need to Prohibit Anger in Order to Maintain and Nurture Relationships

The terrain mapped thus far reveals culturally acquired beliefs about 'ideal womanhood,' and anger. How do the women who experience premenstrual pain acquired as they journey, respond as they realize they must prohibit anger in order to maintain and nurture relationships? Through the acculturation process, women have both been taught to maintain, and to assume the role of the nurturer within relationships (Caplan, 1981; Miller, 1986). The terrain is becoming almost impassable--"Women's sense of self and worth is grounded in the ability to make and maintain relationships" (Miller, 1988, p.2).

> When my husband left me, I felt alone and I knew I was worthless because I didn't have anybody who really needed me or that I came first with. What does it say about me that I can't even hang on to a relationship with a man?

Without relationships many women feel lost, and in some cases, are held up to public ridicule as examples of 'failing to be the ideal woman.' Simultaneously, they are required to maintain relationships so intensely nurturing that they can only experience more anger. This heightened anger, must, in turn, be silenced; more anger results; the process accelerates. Hence, the task becomes impossible. 'Failing to be the ideal woman' further intensifies the desperate attempts of 'trying to be the ideal woman.'

> I know that I have to try harder. My husband told me so and so do most of the other people who are trying to help me. If I just tried harder, I could probably do better.
>
> I know that I have to do a better job of being a good mother and a good partner to my husband. It's just that I am so tired a lot of the time, but I know that other women do it and if I am any good, I can do it too.

This further accelerates the process of 'losing access to the primary self' (sub-BPP). In terms of the map, it is rather as if the women are forced to scale a mountain and to swim a stream at the same time.

Not only does the experience of actually feeling anger put women in a conflict position, but it is also viewed as extremely destructive for women to speak their anger in their relationships. The culture at large blames women and punishes them severely when they 'hurt others' by expressing anger.

> To be angry can feel to a woman as if it will disrupt a relationship in this culture; it exerts a powerful weight, making women afraid to feel those first stirrings of anger. It is a great risk in disturbing the relationships which provide one's economic

> sustenance and whole psychological place in the world. (Miller, 1983, p.2)

One of the rules that this culture has most incorporated into its belief system is the idea that a person can only be one way or the opposite. A woman is labelled as either nurturing or destructive. There is no allowance in the traditional objective, scientific framework for the ability and the right to experience both poles. Since the pain and isolation of being labelled as destructive is too much for most women, there is often no choice except to self-silence anything that hints at feelings of anger. Male members of this culture also experience this restriction and this pain, but male experience is not the focus here.

Culturally Acquired Beliefs About the Necessity of Hiding to Avoid Alienation

Thus far, the journey has brought the women through culturally acquired beliefs about 'ideal womanhood,' enforced nurturing, and anger. These culminate in the prohibiting of anger in order to maintain and nurture relationships. The women know that they have failed to reach the mecca of 'ideal womanhood' ('failing to be the ideal woman'). Increasingly rugged terrain begins to overwhelm them, and they become fearful of what will happen if the extent of their failure is exposed.

Thus, they acquire the belief that hiding is an essential part of the cultural geography ('losing access to the primary self'). The fear of being exposed in their failure as Ideal Women is so terrifying that profound hiding becomes an absolute necessity: alienation is the most severe punishment that almost all cultures hold over members who fail to perform according to the cultural expectations. As women carry a heavy responsibility for making and maintaining relationships, women who fail are, almost by definition, facing the threatening possibility of alienation. They fear being alone and they fear punishment for being alone.

> I know that I just have to be quiet about a lot of my bad feelings. If I let them out and let people see what I am really like, everyone will despise me and I will be totally alone.

Once again, Miller's (1988) comment that "Women's sense of self and worth is grounded in the ability to make and maintain relationships" (p.2) applies. It explains the women's intense belief about the necessity to hide.

Summary of Context

The context of the cultural terrain the women travel has now been traced. Accepting the culturally acquired beliefs about the feminine role--(a) 'ideal womanhood,' (b) beliefs about nurturing, (c) beliefs about anger, (d) beliefs about prohibiting anger to maintain and nurture relationships, and (e) beliefs about hiding to avoid alienation are the context.

Conditions

To continue tracing the women's journey, it is necessary to examine the three significant landmarks that impact them: (a) being a female child in a Western culture; (b) being a child of dysfunctional family background; and (c) experiencing a negative introduction to menstruation.

Being a Female Child in a Patriarchal Cultural Context

These women, as they pass through childhood, experience the powerlessness common to children in the face of adult authority. As children, they are dependent upon adults for survival, and dependency can be as frightening to children as it is to adults. Enforced compliance to adult rules triggers anger that children must hide and deny. Running the risk of losing the affection of adults upon whom they depend is too dangerous, and children learn both to fear their own anger and to fear revealing its full dimensions.

> I remember hating my father because I felt so dependent on him. I had to do what he told me and be what he wanted or else I would not have had a family. The rule was that I had to obey him in order to be allowed to live in my family.

Although the processes described above are common to children of both genders, being a female child in this cultural context intensifies these feelings. The lesson of 'trying to be the ideal woman' requires that female children learn to nurture at a very early age. The consequent anger, fear of exposure, and subsequent hiding are doubly necessary for female children and at the same time confront them with their 'failing to be ideal women.' Thus, 'losing access to the primary self' (sub-BPP) begins very early in the life of a little girl. 'Trying' and 'failing to be the ideal woman' leaves neither room nor time to develop the 'primary self,' and access to it becomes more difficult as the 'secondary self,' demanded by the cultural context is superimposed over it.

> I don't think I ever really had a chance to get to know myself until I was an adult, went to a therapist who was a feminist and started to find out who I really am. Sometimes I look back and feel really sad about the little girl I used to be who tried so hard that she never got to be herself.

Being a Child of Dysfunctional Family Background

Another significant landmark in these women's journeys is that of being raised in dysfunctional families. (see the beginning of chapter 4--the Story) The condition of being a child from a dysfunctional family is a major factor contributing to the women's experience of severe premenstrual pain. Furthermore, it may be a factor that helps to explain why these women were particularly vulnerable to the patriarchal vestiges of their cultural context. Dysfunctional families frequently make desperate attempts to maintain an image of normalcy, and may therefore cling to the most traditional values of their culture in the belief that this will

1. protect the family from exposure of its dysfunctional inadequacies; and
2. rescue the family from the dysfunctional situation and help it return to societal standards of normalcy.

Five of the women whose story is told here made reference to specific incidents of emotional, physical or sexual abuse. For more detailed description of these, the reader is referred back to the beginning of chapter 4.

Dysfunctional families maintain the image of normalcy by an implicit rule, hidden even from each other, that all family members keep secret the family problems. Thus the lessons learned by all children--hiding and secrecy--become of critical intensity in a dysfunctional family.

A sense of failure, of being different, of confusion, and of not trusting are some of the feelings that follow these women into their adult lives. The very nebulousness contributes to the sense of being 'bad' that they develop as children in dysfunctional families. When the cause of painful feelings is unclear to children, it is safer to blame themselves rather than the adults around them.

> When I was little, I always thought it was my fault when Dad got drunk and Mom and Dad fought. Maybe if I had been quieter and hadn't made such a mess, Dad would not have gone out drinking.
>
> My mother always told me that if I hadn't talked back to my father, then he would not have taken that out on her. So I always had to apologize to him and I blamed myself for his rages at my mother.
>
> I knew that our family was different and that I was different, but I thought that it was my fault. My being different made the whole family different.

Early in their childhoods, these women are placed in the position of experiencing not only the anger common to young children, but also the terrible anger that children from dysfunctional families experience. What else can a child feel when, once again, Christmas is ruined because Dad is passed out drunk on the couch? For a female child the unfairness of being forced to learn the lesson of nurturing produces anger: how much more terrible is the anger of a female child who has to nurture dysfunctional parents?

The enormity of 'trying to be the ideal woman' is overwhelming. For these women the immensity of the task is multiplied many times and, hence, 'failing to be the ideal woman' is brought home much more quickly and destructively. The process of 'losing access to the primary self' (sub-BPP) that female children experience is accelerated. In these dysfunctional families, one child, often a female child, assumes the responsibility for nurturing the parents and maintaining the family unit. Therefore, it is rather like time lapse photography in reverse: the process of 'losing access to the primary self' accelerates.

Experiencing a Negative Introduction to Menstruation

The White Pad

... in math one day I lost concentration.
my sixth grade teacher began to float
at the board; her column of figures toppled.
I lurched from my seat into the hallway,
through wide swinging metal doors,

to cold white hexagonal tiles, gray stalls
standing at attention. My feet slid across
the floor like tankers crossing the Red Sea,
refusing to be hurried in the face of bomb's blasts.
beyond yellow cinder block walls

the nurse held out the white cotton pad,
its gauze flaps dangling, and two strong
steel safety pins, to anchor the tiny craft
against the surge of the oncoming sea.

Phyllis Winston
(cited in Taylor, 1988, p.9)

The onset of menstruation is one of the most significant landmarks that all women pass on their journey through life. For the women with whom I dialogued, the introduction to menstruation was particularly significant. Their introduction to menstruation was described by them as being a negative experience.

The women in this study may have been more vulnerable to any negative intimations about menstruation as it was explained to them, because, as children of dysfunctional families, they may have developed the heightened sensitivity frequently found in children from such families. This sensitivity can be a protective device on the part of the child who must always be aware and on the alert for the possibility of impending family conflict.

In addition, the dysfunctional nature of the family unit may have made it more difficult for the mother (or either parent) to present menstruation in a positive light. Dysfunctional families may be in such distress that any change, in the absence of therapeutic intervention, can be viewed as negative, and threatening to the precarious family balance.

Furthermore, as has been discussed previously, these families may have internalized the negative values commonly associated with menstruation in much earlier times. The adherence to extremely traditional beliefs about menstruation would reinforce extremely patriarchal aspects of Western culture long abandoned by healthier family units.

The secrecy in which menstruation is cloaked only confirms for them the need for hiding, and intensifies their feeling about their own innate 'badness.' Now they view their bodies as giving them a monthly reminder that they are 'bad.' Intense anger at their own bodies' betrayal of their need to hide, results. This anger is fueled by their realization that what limited childhood freedom they have experienced prior to menstruation is now more limited: 'trying to be the ideal woman' must now be their major life's work. 'Losing access to the primary self' (sub-BPP) intensifies because they will now have even less time to access what remains of the 'primary self.'

> My mother told me that now that I had my period I had to grow up and start acting like a lady. She said it was time that I learned about running a house and doing the things women do.

The emphasis on covering up and concealing the evidence of menstruation--the bulky pads, the references to dirty or soiled napkins, the concern about hiding the evidence of bleeding--all of these are added to the list of baggage they must carry with them as they travel. Anger, secrecy, hiding, feeling one is bad --all of these are graphic demonstrations that they are 'failing to be the ideal woman.'

Paradoxically, while the negative introduction to menstruation contributes to the women's feelings that they are somehow 'bad,' this same negative experience plants the seed that may, much later in their lives, assist them as they heal. Why?

The lack of celebration of what, in a different context, would be viewed as a beautiful landmark is painful: some distant fragile voice from the 'primary self' sends a message that this is not the way it ought to be. The young woman feels that something is wrong. Surely she and her mother should be able to 'connect' and share a sense of a rich, woman-to-woman bond of closeness. Why can't her mother help her face this indisputable proof of femininity with joy, not shame?

The young woman may sense that her mother was denied her own affirmation and celebration many years ago, and that all the rituals of woman-validating-woman have been taken away. Her mother possesses only the bitter taboos of the patriarchy of earlier times instilled in her (Cameron, 1981; Weideger, 1976).

On the one hand, this link of fleeting connection with the 'primary self' leaves the young woman with a sense of pain for what is missing. On the other hand, it may give a faint glimmer that what has been done to herself, her mother, and all women is wrong. The need to connect with other women, in one of the most powerfully female experiences, is a first glimpse of what a young woman could have if she could somehow connect with other women.

It is as if, in her struggle to travel through the bleakness of the cultural terrain, she finds one tiny piece of land that hints at beauty, and finds a tiny seed lying on the ground.

> I just had this feeling that somehow it was all wrong. My mother and I should have been able to sit down and talk about it and really share our feelings. I felt sad for her that she was so embarrassed and I wanted to tell her that I loved her but I was too overcome by her sense of shame. I still think that it should have been different somehow and I am determined that I will celebrate my daughter's experience.

Although she cannot stay, the hope that she will somehow, someday find a ground which is her own gives her the encouragement to pick up the seed and tuck it away as she journeys on. This sense that there is other land to travel--land in which she is not an unvalued stranger, pathways of her own rather than those imposed on her--is all she can take with her, just this and one tiny seed.

Summary of the Conditions

Just as a traveller takes out her map and looks at the landmarks she has circled to recall her journey, it is time to review the landmarks (conditions) for the women whose story is recorded here. The first condition is that of being a female child in a patriarchal cultural context. It is the women's introduction to 'trying' and 'failing to be the ideal woman.' In combination, these two parts of the negative feedback loop, contribute to the sub-BPP of 'losing access to the primary self.' The second condition is that of being a child of a dysfunctional family background, which intensifies the negative feedback loop of 'trying' and 'failing to be the ideal woman,' and 'losing access to the primary self.' The third condition, experiencing a negative introduction to menstruation, further intensifies 'trying' and 'failing to be the ideal woman'and accelerates the sub-BPP. The women's lives and their experience of the premenstrum are shaped by these conditions.

Bleeding to Death

I always get "crazy"
when I bleed.

As if all the years,
the centuries
of oppression
swell up inside me.

Then painfully push/out
expelling

the stench
of ancient
garbage.

Sherry Lee (cited in Taylor, 1988, p.68)

The Premenstrual Experience--The Turning Point

It is now time to remind the reader of the original metaphor for these women's experience of premenstrual pain.

> If the context of the terrain, the conditions are the landmarks, and the journey of the women's lives is the roadway; then the women's 'PMS' experience is the roadblock--a roadblock that becomes an impasse in their lives ... this is the turning point: the impasse of severe premenstrual change forces the women off the roadway and into a desperate search for a way around the roadblock.

The premenstrual experience serves to confront these women with 'failing to be the ideal woman.' On one hand, it is the focusing mechanism by which they gain awareness of the faint possibility that the 'primary self' is still with them and may eventually be accessed. The physical and psychological changes accompanying the premenstrum, force the women to turn inward, thus increasing their chances of eventually accessing the 'primary self.'

> Miserable as I am before I have my period, there are times when I almost feel good about it. It seems like it's one time when I get close to finding out how I really feel about some hidden parts of myself. At the same time that really scares me.

On the other hand, at this point, they do not experience the premenstrum as a gift because they are still 'trying to be the ideal woman,' the physical and emotional chaos of the premenstrum is perceived, from the 'ideal womanhood' perspective, as the ultimate curse.

Strategies

The strategies are the detours taken by these women in their attempt to circumvent the road-block that the premenstrual experience throws in the way of their journey of 'trying to be the ideal woman.' However, the detours lead only to a dead-end: their premenstrual experience does not change significantly. All detours take them back to the same impasse. Not only is 'failing to be the ideal woman' undeniably confirmed for them, but they also experience the anger of having tried every possible remedy, only to fail.

For the purposes of discussing the strategies and avoiding endless repetition, the reader should be clear that each strategy has the effect of intensifying the negative feedback loop of 'trying' and 'failing to be the ideal woman,' and of 'losing access to the primary self' (sub-BPP). The women continuously move between 'trying' harder, leading to 'failing' more, and 'failing' more, leading to 'trying' harder.

a. Denying

An important protective strategy or attempt to detour around the impasse, is that of denying. As a strategy, denying requires that the women cannot allow themselves to believe what they feel: they must force themselves to remain unaware. Another strategy, hiding, is closely intertwined with that of denying. However, hiding, necessitates some level of awareness of what needs to be hidden; and denying is defined as "to practice selfabnegation" (Oxford Universal Dictionary, 1964. p.482). The overt actions of hiding and denying appear similar; the process is different.

The predominant ways of hiding and denying are to show feelings that are in opposition to the actual feelings, in order to please the other. These women behave 'as if.' A life-long pattern of denying their own needs in order to serve others has already been set in place by the cultural context.

> My parents insisted that I be happy because they said that it made other people sad to see me cry.

The female child is usually taught to win approval for her performance of the task of looking after others at the expense of her self (Caplan, 1981). Denial is an essential aspect of 'trying to be the ideal woman,' and what is being denied is the expression of the 'primary self.'

> I got a lot of pressure from my parents to give all of my Easter candy to the boy next door because he was in a wheelchair. They said that was a really nice, unselfish thing to do. They also said I didn't need the candy because I might get fat and wouldn't be able to wear nice clothes and I was too old for candy anyway. I always wondered why they didn't pressure my brother to give his candy away when he got to be 13 and was heavier than me.

b. Hiding

As children, these women learned, as all children do, to hide undesirable behaviors from adults: hiding parts of their inner selves is necessary for all children because of the tremendous power adults have over them. The advent of menstruation brings into play two factors that intensify hiding. First, as adolescent girls, they were taught the necessity to hide this natural physiological function (see chapter 4--Early Menstrual Experience). Second, because menstruation symbolizes adult femaleness, the cultural demand that women portray the 'ideal woman,' intensifies (see chapter 4, Early Menstrual Experiences).

All the women describe hiding as being a necessary part of all of their relationships during the stage of 'trying to be the ideal woman.' Hiding serves two important functions: protecting self from exposure, and protecting others. The Oxford Universal Dictionary (1963) defines "to hide" as

> To put or keep out of sight; to conceal oneself; to conceal from the notice of others; to secrete; to keep from the knowledge of others; to keep secret; to prevent from being seen. (p.899)

These women learn to hide knowledge of their inner selves from themselves; further, they must deny or disown any parts of the self that are unacceptable to others. Hiding becomes essential for self-protection: without it they face possible exposure, and fear resultant rejection, ridicule and punishment. Hence the ultimate fear of alienation looms closer.

Hiding becomes a driving force in these women's lives. First, they learn the hiding necessary to all children. The necessity for childhood hiding is intensified because of a dysfunctional family context. Second, the treatment of menstruation in their adolescent experience augments hiding. Third, as adults, their fear of 'failing to be ideal women' confirms for them the need to hide. In addition, they learn through painful experience that all intense emotion, particularly anger, must be hidden from themselves and others.

A common way to conceal anger is suggested by Miller (1983). "...anger is not conveyed and is expressed via the only route: symptoms, either psychic or somatic (the most common being depression)." (p.2) Thus, these women are forced to turn anger literally in on themselves.

c. Normalizing

Another way of trying to detour around the roadblock, of 'trying to be the ideal woman,' is 'normalizing.' Normalizing is the umbrella term for social strategies that enable one to proceed with life's activities 'as if' everything is normal--by 'keeping up' and by 'covering up' (Weiner, 1975).

Keeping up incorporates those strategies employed to enable one to proceed with normal activities. Covering up strategies are those used to conceal the problem of 'failing to be ideal women.' Some women engage in what Weiner (1975) describes as 'supernormalizing' or excessive covering up.

Successful covering up and keeping up can leave these women in an ambivalent position. Relationships and activities can be maintained as usual, for most of the month. Thus, when keeping up becomes impossible during the premenstrum, inaction becomes difficult to justify (Weiner, 1975). Most of these women are very effective at keeping up most of the time, regardless of whether they feel healthy or not. It then becomes very difficult for them to legitimize inactivity and/or to reveal pain when they are so unwell that they no longer have the energy to hide their unwellness.

> My family doesn't seem to believe me when I say I am in so much pain that I have to go to bed. They say, 'You were fine this morning and you went to work. Why are you sick now?' What they don't understand is that I have been in pain for days.
>
> Before I have my period, I try to pretend that I feel fine. I am usually pretty good at it, but sometimes covering up takes a lot of energy and makes me feel worse inside.

Covering up, or behaving 'as if' during the premenstrual time, is a process designed to ensure one's true experience is not exposed for the viewing of others. Masks are worn--"I wore the mask of Miss Mary Sunshine"--in order to cover or to protect the wearer from exposure. Masks are designed to conceal the real nature or meaning of something from the other.

Actors engaged in a theatrical production where they must wear masks are warned that this can be dangerous: mask-wearing, even temporarily, can produce a set of interlocking ambivalencies. The actor may try to become the character represented by the mask and, consequently, may experience a dangerous loss of self. The actor may end up being unable to distinguish between self and the mask. If the stage character depicted by the mask fits too well, the actor may become unable to distinguish between the mask and the self. On the other hand, if the mask does not fit well, the actor may try so hard to make it fit that a loss of personal self results.

In addition, covering up is also perceived as being a 'good' feminine quality and is related to self-effacing or the erasing of the self in a desperate attempt to make the 'Ideal

Woman' mask fit. It is also a way of discounting and devaluing the true self. "If people really knew what I was like, I wouldn't have any friends." Again, because connections in relationship are crucial for women, they become desperate to maintain them, even in the face of covering up their true feelings.

d. Comparing Self to Others--Choosing Relationships as Adults "Women's sense of self and worth is grounded in the ability to make and maintain relationships" (Miller, 1988, p.2). Women struggling to be the ideal believe that they must make and maintain ideal relationships with ideal men ('trying to be the ideal woman'). In a patriarchal culture, the status of a subordinate is often determined by the status of the dominant to whom she is partnered.

In their striving to be the 'ideal woman,' women often form relationships with those who meet the image of an 'ideal man' (some of these women are married to lawyers, police officers, and military officers). In this culture, such men are perceived as having great power, although ironically this power stems from being both rule enforcers and peace keepers.

In addition, women who are striving to be the ideal form relationships with other women who appear to epitomize 'ideal womanhood.' In their stories, the women tell, of friends who are the epitome of 'ideal womanhood.' Common to all of the women, was a strong belief that if they revealed their experience of the premenstrum, their friends would reject them.

> My friend is such a wonderful person and has everything under control so much, that I could never tell her how I fall apart. I know she would never yell at her kids.

Paradoxically, the women have chosen ideal women friends in order to confirm their own fragile sense of self-worth; however, having such friends confirms for them that they are failures and can never measure up ('failing to be the ideal woman'). The paradox is grounded in the roots of the cultural context: to maintain the role of the 'ideal woman,' friendships between women are very limited and restricted. Thus, the rich woman-sharing connections that Miller (1988) describes as essential cannot thrive.

Unable to share their experience with other women (due to fear of rejection and alienation), they share in the only realm possible--they voice their pain to their male partners. Experiencing severe premenstrual changes, while partnered with an ideal man, provides further confirmation of 'failing.' How can any woman not view herself as a failure when she is fortunate enough to be in relationship with a man regarded as the epitome of the ideal? Self-hatred, self-condemnation, and guilt may result. These feelings are intensified when the women try to express their feelings about the severe premenstrual changes in an attempt to build a 'connecting' relationship (Miller, 1988) with their partners. However, what results is a 'disconnecting relationship' because the partners are solution-oriented and provide practical remedies via advice. This denies the women's needs to express and share their experience of pain (Miller, 1988).

This interaction between the women and their male partners serves several protective functions. Although the disconnecting relationship problem is already exposed, focusing on the premenstrual experience protects both partners from examining and facing other difficulties in the relationship.

For the female partner, however, this response provokes additional problems: (a) at a time when she is already overwhelmed, she is given more overwhelming advice to follow; (b) being unable to implement the advice successfully (to fix her severe premenstrual changes), intensifies her sense of 'failing' and guilt; and (c) profound confusion occurs, because a problem-solving relationship is substituted for a connecting relationship.

On one hand, she feels a deep sense of anger at being offered makeshift solutions when she needs deep sharing. She does not understand the source of her anger. Therefore, she internalises a greater sense of 'failing' and experiences more disconnection (Miller, 1988). On the other hand, she feels guilty: shouldn't she be grateful to her partner, who is a good man, genuinely trying to help her? Observing her male partner's real pain over his inability to help her, and his sense of failure at being unable to suggest effective remedies (remember, male partners are 'ideal men') accelerates her guilt and distress. Ambivalence and paralysis are intensified.

Thus, the women reveal in their stories a pattern of comparing themselves to others, and they feel themselves to be inadequate in such comparisons. They express statements about comparisons similar to that described in Holmgren's (1987) research describing women's experience of depression.

> ... regardless of the kind of comparison, or in what context, most (women) left the comparison with a lowered sense of self-worth or self-esteem. (Holmgren, 1987, p.80)

Comparing themselves to others in order to avoid doing anything wrong, locked as they are into 'trying' to be Ideal Women, is the strategy these women develop to avoid exposure. Lacking deep connections with other women, they are forced constantly to compare their behaviour and performance against that of their "wonderful" male partners. ("Wonderful" is the adjective used by 5 of the 6 women, and should not be construed as sarcasm on the part of the narrator).

The women describe these men as always supportive, caring, stable, and "flat". An intensive effort is made to model on their male intimates and to ensure 'sameness' all month. During their premenstrum, they find it almost impossible to be supportive, caring, stable, and flat.

e. Anticipating

Anticipating is another strategy used for detouring around the roadblock of the premenstrual experience. Those who have regular cycles, anticipate the onset of the premenstrum with dread and devote tremendous energy to planning their lives around it. The women with irregular cycles experience even greater anxiety: how can they prevent exposure when they do not know when they may "lose control" and therefore, expose themselves? One group is paralyzed by the anticipation of what they dread; the other by what they cannot predict.

f. Seeking Expert Help to Eliminate Symptoms

The ways in which these women seek expert help as a means of eliminating the 'symptoms,' are demonstrations of Montgomery's (1982) description of the theme of giving personal power away through wanting to be the child who is mothered. The women appear to sense that their female friends, exhausted by nurturing demands, cannot meet their needs and cannot mother them as required. In addition, they cannot seek help from other women because they believe that they will be rejected: speaking of their pain will reveal their 'failing' to be 'ideal women.' "I couldn't tell my friend about what was happening to me because she had her life so together."

Thus, one of the ultimate ironies of living in a Western cultural context is that at the time adult women need female mothering care, they must go to men. As Miller (1988) states, this results, at least in part, from the disconnection women experience. Therefore, what is needed as they are simultaneously 'trying' and 'failing' to be 'ideal women,' is a male authority figure perceived as making things better. "I felt that the only person who could help me was my doctor (male physician) and I clung to the idea that he could give me something to fix this."

In part, this explains the seeking of 'expert help,' which takes place during this time, versus the seeking of inner help and collegial help which takes place later. In their desperation, these women view the experts as the only ones capable of taking the symptoms away, and therefore eliminating the intense pain. If the symptoms can be 'removed,' then the cyclical reminder of 'failing' will also be taken away.

It is only after years of experiencing life through this lens of 'trying to be the ideal woman,' resulting in feelings of craziness and desperation, that expert help is sought. Weiner (1975) suggests that, in part, this hesitation to seek professional help stems from the fear of dependency, and that it increases the strain of tolerating the uncertainty of when and how this experience will reoccur.

In addition, seeking professional help prevents one from successfully normalizing, and specifically, successfully covering up. In essence the 'cover is blown' and the 'mask is removed.' "When I started talking about my 'PMS' I felt like my mask had been taken away; I felt exposed."

Most of the helping professionals consulted during this time ignored the women's requests for understanding and support, discounted and minimized the severity of the experience as the women described it, or responded in other ways that were not empowering of these women. There were three exceptions to this rule. One was a nutritionist who clearly attempted to respect the experience as it was described by the woman who consulted her. The second was a male gynecologist who was consulted after the woman had experienced some healing. He listened, confirmed, and validated her experience. The third exception was the feminist therapists that some of the women eventually connected with. (The relationship between working with feminist psychologists and healing will be addressed in chapter 7).

It is possible that the helping professionals consulted adhere to the maintenance of the status quo for women. In other words, their work is based in a philosophy that supports helping women adapt and better function in their assigned roles. The attitudes of the professionals intensify the women's feelings of 'failing': they are disconnected from other women, they are disconnected from male intimates, and finally from the helping professionals. The women are provided with further proof of 'failing.' Repeatedly, the helping professionals tell them that the 'problem' is "your responsibility" and "you must do something, because you can see that this is destroying your marriage and your family." What further proof of 'failing' do they need?

g. Attributing

Attributing is another strategy used by the women in their pursuit of 'trying to be the ideal woman.' They strive to find a cause for all of their 'failings'--they believe their premenstrual changes are the ultimate demonstration of 'failing's that they can hide the rest of the month. Attribution is used to lay blame on themselves for 'failing.' An example of attribution is

> If I stopped drinking coffee, then I would not feel so irritated. Our marriage is falling apart because I can't stop my anger; if I could only stop being a bitch, then everything would be okay.

As a consequence of the societal emphasis on linear causality, women who are experiencing severe premenstrual changes attempt to eliminate both their symptoms, and their anxiety over the symptoms, by engaging in more attribution strategies. They are locked into finding causes for all symptoms. Self-help books and professional information, however well-intentioned, confirm their belief in linear causality. Both offer simplistic explanations of cause and effect (about 'PMS') and suggest remedies that are held out as bringing relief. This is not to say that all self-help materials and professional information are damaging to women. They can be very useful when women are ready to heal from a deep inner connection with self. It is not that the information provided in the self-help books cannot be helpful, it is the women's desperate focus on grasping at the remedies that exacerbates the difficulties.

During this time, more anxiety is created. If the women put the remedies into effect, and still experience no relief of symptoms, they blame themselves. Furthermore, they renew their search for additional causes and remedies. "... if these attempts are unsuccessful (as they have to be) it then makes sense to try more of the same." (Watzlawick, Weakland, & Fisch, 1974, p.57). If the women lack the energy to put the promised remedies into effect, they also blame themselves ('trying' and 'failing'). Note the circular nature of the trap.

Attributing strategies produce tremendous anxiety and require enormous energy at a time when energy is most limited. The attribution process spirals into blame, despair and paralysis.

h. Hoping

Regardless of the intensity of the experience, all of the women live with the hope that they can make a difference, if only they talk with the 'right person' and do the 'right things.' The hope here is that doing the 'right things' will control and eliminate the 'symptoms' and enable the women to be successful in their attempts to be 'ideal.'

Another aspect of hoping is that of hoping that everything will be different next month. One woman describes her frantic search for the right answer and speaks of admonishing herself repeatedly "if I will just try harder and do better at my yoga routine, then next month has to be better."

These women are caught in a juggling process while 'trying' and 'failing to be ideal women.' The hope of relief is constantly being juggled against the anticipation of reoccurrence (Weiner, 1975). Weiner describes the hoping for relief as a psychological strategy that is developed against the dread of a progressively worsened state. This strategy is clearly voiced by all of the women.

> I kept trying each month to make a difference, to stop this from happening to me, but I knew that I could get to that time of the month, and find out that it was only going to be worse.

The strategy of hoping has the unfortunate effect of entrenching them in the problem. Furthermore, this particular strategy traps them in the search for a cure from the experts. Thus, 'failing' (even to find a cure) contributes to their guilt and anxiety, further exacerbating the situation.

i. Holding Back and Letting Go

Holding back (not saying or acting on what one feels) and letting go (expressing what one is feeling) are two seemingly contradictory strategies employed in the process of relating to others. Each of these strategies is context-specific. Holding back is a strategy used by these women when relating with casual acquaintances and at work. Letting go is a strategy employed when interacting with intimates (children, partners). Both strategies are described by the women as being destructive to others and themselves. Holding back is another way of wearing a mask.

> I kept everything in at work, because I couldn't show my anger to my colleagues at work, and then I went home and yelled at my husband and kids.

As with any form of denial, the feelings are stored internally and cannot be directly expressed ('trying to be the ideal woman').

Letting go is reserved for relating with those close to the women. "My husband was the only one I exploded at;" "the only people I yelled at were my children." The intensity of emotion expressed when the women let go, is perceived as creating pain, both for themselves and for their intimates ('failing to be the ideal woman'). The woman and her partner are both baffled, because the intensity of emotion often seems to be inappropriate to the triggering event. This reinforces the women's belief that they must hide all emotional intensity.

j. Isolating Self

Isolating the self is achieved by decreasing social interactions with others and is another strategy used by the women in their attempts to detour around the impasse of their premenstrum. During their premenstrum, the women seclude themselves from social interactions (family gatherings, parties, dinners with friends). They also attempt to shut themselves off from their intimates in order to avoid the devastating consequences of letting go. It is critical that others not be aware that one is not the person that one presents to the outside world ('trying to be the ideal woman').

These women are neither able to deny their intense emotions during their premenstrum, nor are they able to hide these emotions ('failing' to be the 'Ideal Women'). Thus, the only way to protect themselves is to stop interacting with others during this time.

> I planned my life so that I would not have to deal with people when I was premenstrual; I found that I began not wanting to be around people, because I couldn't trust what I would say or do; people would know what I was really like if I was around them while I was premenstrual.

Summary of Strategies

The 'failing' of the strategies, the attempt to heal from the outside in, puts the women in a terrible position. As they implement the strategies, they undergo a horrifying experience:

the more they fail, the harder they try; the harder they try, the more they fail. This is paralysis. What are the consequences of expending all consuming energy to detour around a roadblock only to arrive back at the same impasse?

Consequences

The culminating effect of the strategies that the women employ in their attempts to detour around the premenstrual impasse is an intense cycle of 'failing' and 'trying.' This process is analogous to that of a driver losing control of her vehicle after her many efforts to get around the impasse have only succeeded in plunging her off the road altogether. This plunging sends the women into a void.

Spiralling of Rage Leading to the Belief in Craziness

This void is the spiralling of anger into rage. For the women whose life journey has lead them off the roadway, via unsuccessful detours around the premenstrual impasse, the consequence is rage. All the burgeoning anger they have acquired, as they have travelled from early childhood through the context and conditions of the cultural terrain, explodes. On the one hand, they experience the paralysis of 'trying' and 'failing;' on the other hand, they react to the shattering futility of their previous efforts with rage. Where does this leave the women?

To return to the metaphor of the map, the women lose control of the vehicle of their own lives and plunge off the road altogether. They are catapulted into a void. Here it is useful to recall the women's description of their experience as they are hurled away from the path they have tried to follow. It is important to remember that these particular women have expended enormous energy 'trying' to follow the pathway of 'ideal womanhood,' perhaps because of their need to compensate for a dysfunctional family background.

They speak first of feelings of anger turning into rage, next of acting crazy, then of feeling crazy, and ultimately of being crazy.

> I'm crazy. My rage um ah isn't just anger anymore. I threw a coffee table against the wall because my little boy left his jacket on it. Now that is crazy. He was terrified and I told him he deserved to be scared. That is really crazy. I'm not cruel, (crying) I'm crazy.
>
> It's just that it has something to do with wanting no human contact ... because I am afraid that I will blow up. My God, like this is just a nutso person inside of me who is saying all these crazy things. Having a nutso person inside of you means that I am really crazy I know that I must be crazy. No one who is sane can be this angry. I don't trust myself because I am afraid of what might happen if I ever lost control when I am in one of my premenstrual rages.
>
> One of the reasons I know that I must be crazy ... um ... is because if I were sane, I um would never act like that around my kids because (crying) that's how my father acted when he was drunk. I always said that I'd never do that. (pause while crying) I know better than most how awful it is when kids are made to feel that it is their fault, a parent is acting crazy. I must be more crazy than anyone else.

In order to appreciate the enormity of the women's rage and the anguish of their feeling crazy, it is useful to reframe the map.

> The kind of anger that we have postulated (calling rage) is not originally there, the environment created and shaped it, it is not intrinsic, but is developed by a cultural structure that first incites an angry

> response, and then compounds the problem by not allowing individuals to fully acknowledge or to know the response, nor to act on it ... and you have to have experienced hurtful and simultaneously disavowed the experience in order to acquire the kind of anger that we associate with the most terrible and terrifying rage, usually called helpless rage. (Miller, 1983, p.8)

For the women whose story has been recounted, "the most terrible and terrifying rage, usually called helpless rage" (Miller, 1983, p.8) is what they name 'being crazy.' At this point on the map, the 'failing' of the strategies has the consequence of making the women act, feel and believe that they are crazy.

Remaining Trapped

What happens next? Do these women stay suspended for the rest of their menstruating lives in the abyss of believing they are crazy? Some of the women speak of remaining trapped: for them the premenstrum, at least at the time they shared their history with me, is still an agonizing experience of acting crazy, feeling crazy,and believing they are crazy.

These are the women who, using the incredible strength and courage that women possess even in the midst of pain, manage to struggle, for at least part of the month, out of the abyss and continue their search for new detours around the roadblock. It must be noted here, that while these women still experience acute premenstrual difficulty, the very reality of their courage to keep 'trying,' in the midst of 'failing,' may well sustain them until they are ready for healing to begin.

Exposing the Fiction of Ideal Womanhood (Core BPP)

What of the other women in the story? They tell of experiencing a different premenstrum than the women who are still searching for strategies (remaining trapped). Although the second group speaks of having undergone agonizing premenstrums previously, this is no longer their situation.

They report 'feeling better' and of no longer feeling desperation and rage. They no longer believe that they are crazy. These women speak of knowing that, even if they do feel crazy at times, (and who of us does not?) they are most definitely not crazy and know it (core BPP--Exposing the Fiction of 'ideal womanhood').

> Now I know that when I feel that way (crazy) that all I need to do is get away for awhile and do something that I like doing. I know that I'll feel better after that and that I probably need to get some rest and not feel guilty about it.

> Now I feel different. At times if I feel that I am really losing it ... I just say look ... 'you don't really need me around here ... for now ... and like this, and goodbye ...' and I am gone. ... Oh, well, I maybe go shopping, maybe go to my office, maybe go and visit my sister ... just anywhere to get out of that environment.

They tell a story of their own healing. They no longer perceive healing as an absolute, linear, and finite process. These women no longer expect the one perfect cure, or hope to discover an arsenal of remedies guaranteed to banish all premenstrual pain.

> Now I know that each month my premenstrual experience will be different and so I know that I can learn what I need to do as I go along. I know that what I do last month may not be as helpful this month and I almost

enjoy learning about myself in this way.

Interestingly enough, some of the strategies that had failed them in the past, are now effective.

What has happened to them? Why are some women healing, and not others? How can some of the women escape the abyss, while others still experience the terrible rage of 'trying,' 'failing,' and being plunged back on a monthly basis?

Realizing That Trying and Failing are the Same

The answers can be found in the context and conditions of the women's lives. The negative feedback loop of 'trying to be the ideal woman' and 'failing to be the ideal woman' has affected all of these women for all of their lives. Immense energy has been expended in 'trying to be the ideal woman;' paradoxically, enormous energy has been exhausted in attempts to hide 'failing' (to be the 'ideal woman'), both from themselves and others.

As women born in a patriarchal cultural context, they are taught to believe that these two parts of the negative feedback loop ('trying' and 'failing') are opposites. Thus, their dysfunctional family backgrounds, and their negative introduction to menstruation combine with the patriarchal aspects of their acculturation to keep them subordinate. 'Trying' to accomplish an impossible task leaves very little, if any, room to question the rules of the dominant order.

'Failing' to do this task (i.e., achieve 'ideal womanhood') --a task they believed was quite the opposite of 'trying'-- confirms for them that they deserve to remain subordinates.

Furthermore, it guarantees that they will expend catastrophic amounts of energy 'trying' harder not to fail.

The premenstrum acts as a Turning Point, because it leads them to the impasse of the terrible consequences: the harder they try, the more they fail; the more they fail, the harder they try. At first, this paradox paralyzes them. Paralysis is a trap of particular vulnerability for them. This vulnerability is rooted in the ambivalence they have carried with them as a result of both the conditions and the context of their lives.

Next, they respond to 'trying' and 'failing' as the paradox it is: an apparent contradiction in terms, that upon close examination, is no contradiction at all (core BPP--Exposing the Fiction of 'ideal womanhood'). This realization, in itself, is healing in its first embryonic stage. (The reader is asked to take a personal detour on the route towards understanding this theory as its explanation unwinds).

What happens is analogous to flipping a coin at incredible speed. As the coin flips, it is seen differently. The beholder sees the two sides as one and the same. Analogously, the two 'trying' and 'failing' are seen as one and the same. The women who perceive 'trying' and 'failing' as one and the same have reached healing in its first embryonic stage.

Why? As soon as these women perceive 'trying' and 'failing' as one, they realize the futility of 'trying' to do something that is impossible, and therefore destined to fail. What is the point of doing something that forces one to fail? The cultural mythology and its patriarchal overtones have lost their hold and the process of Exposing the Fiction of 'ideal womanhood' (core BPP) can begin. The women are free of the myth and can begin the journey of self discovery. The context and conditions that have controlled most of their lives may not have changed, but their inculcated preoccupation with filling the prescribed role has changed.

> When I saw that everything I was trying to do and to be was impossible, I began to feel better. I am not sure why, except that I felt more free to be myself. Because I felt less guilty, I began to make time for what I needed.

Thus, the experience of the premenstrum is the Turning Point from pain, to healing in its embryonic form. As the coin flips and two sides are seen as one, the women perceive a side that they have not previously been able to access. This side of the coin has been lost to their perception: it is the 'primary self.'

Thus, the sub-BPP of 'losing access to the primary self,' begins to flip as well. As this sub-BPP begins to flip, its opposite side is revealed. The possibility of accessing the 'primary self' is the other side of the coin.

Conclusion / Transition

Now it is time to shift the focus away from the theoretical aspect of the roadmap and return to the women and their journey. The women who have not yet reached the Turning Point are still at an impasse; they continue to search for detours by seeking endless strategies.

They do not--or at least not at the time of sharing their story--perceive the two halves of the coin as one, and until they do, are likely to continue the agonizing process of 'trying to be the ideal woman,' and 'failing to be the ideal woman.'

However, the incredible strength, courage, and integrity they shared with me in their determination to find a road to health is a sign of the rich potential of their own healing. The other women--those who either see the two sides as one, or who are just beginning of seeing the coin flipping--are now free to leave the roadway of the 'ideal womanhood,' and venture into new and uncharted territory: the terrain of their own lives.

7. HEALING

Given the passion of pain, hopelessness, and paralysis described by the women who tell this story, some might question how healing can occur at all. The reader may be skeptical about the apparently abrupt move from paralysis to healing. How can this be?

I could be accused of resorting to a literary device favoured by the ancient Greeks in their plays and myths: The Deus ex Machina ending (translated literally it means a God from a Machine), a theatrical device used to rescue the main players when no human solution could possibly save the day.

A god would be lowered on to the stage, using an elaborate set of pulleys and levers, and this mythical god would use his/her superhuman powers to reverse the tragedy. In modern storytelling and playwriting, critics refer to a Deus ex Machina ending as an indication that a writer is trapped and lacks the artistic skill or integrity to find an ending to the story. Thus, an ending has been imposed from outside-in, and this ending does not fit.

Such is not the case in this story. There are no mythical gods, no artificial contrivances, no desperate attempts to reconcile the truth with a happy ending. The women's story of their healing has its own integrity and cannot be compromised. How they reach out to healing, against incredible odds, can only be considered questionable by those who fail to acknowledge all women's stories for the entire span of women's history.

Women's history has always been a saga of reaching out for healing against great odds--even when health was reduced to bare survival. It is a history of courage in the midst of fear, integrity maintained underneath masks of enforced artifice.

Looking at how the women in this story reach for healing can be done most powerfully by returning to the analogy of the Deus ex Machina ending. The flaw in the Deus ex Machina is that it violates the integrity of the story by imposing an outside, and therefore contrived and artificial, solution. In literary terms it is required that a story-teller achieve resolution of the central conflict by working from within the context of the story and the characters. Writing with integrity requires that resolution be achieved from the inside-out. Analogously, the women who shared their story of healing and who gave me the privilege of telling it here, continue in the process of healing from the inside-out.

Interestingly, their earlier attempts to heal themselves from the outside-in, by imposing elaborate physical regimens on their bodies, did not ease their pain. When they began to heal from the inside-out, by reaching and honouring their inner selves, many of the previously tried strategies began to ease their pain.

The Bridge From Pain to Healing--A Preamble

Some women among those whose story is narrated here, have moved off the cultural highway ('exposing the fiction of ideal womanhood'--core BPP). They are exploring new territory, the land that belongs to them as women and that offers the experience of healing from inside-out.

I confronted a dilemma as the old map no longer traces the journey the healing women are undertaking. Should I create a new map in order to follow their travels? For them so much has changed or is changing. Or should I attempt to find room for healing on the old map? After all, the 'Turning Point' in their experience of the premenstrum is recorded there, and it is there that the embryonic stage of healing begins.

Upon reflection neither course of action appeared very satisfactory. Trying to find room on the old map required forcing what is, in reality, a entirely new theory into a very small space--a space not designed for this task. Surely the story of women's healing deserves better. After all, women's lives have been forced into the sequestered space their cultural context allows them. The very record of their history is limited to what a culture, still fraught with vestiges of the traditional patriarchal beliefs, will allow to be remembered. Even the rituals of menstrual celebration, a rich source of woman-to-woman connection, have been lost, and are only recently being reclaimed.

Thus as a woman, as a feminist, and as a feminist therapist, I have an ethical responsibility to ensure that both theories--the theory of premenstrual pain and the theory of its healing--are treated with the respect and full richness they deserve. Therefore, the complete theory of women's healing via the premenstrual roadway will not be told here.

However, this creates yet another dilemma. Again, as a woman and as a feminist, I share the urgent concern experienced by feminist healers over the dearth of literature about women's processes of healing. Women experience so much pain that it is unbearable to leave this story, and the women in it, without leaving some record, some signpost of healing, for those who have made and will make the same journey.

Therefore, an ethical resolution is afforded by returning, once again, to maps and metaphors. A brief outline map, tracing the main signposts of the journey into healing, will be offered. This is the gift offered by the women whose story of pain is recorded here, and by the narrator who was privileged to record it. It is a gift to all women who experience pain.

An Outline Mapping the Healing Journey

I will not attempt to expound or develop a new formal theory of healing. My purpose is to focus on the experience of the women healing, and it is crucial that the integrity of their healing experience not be sacrificed to theoretical concerns.

It is necessary to take a brief glimpse at the old map as it records the Turning Point (the premenstrual experience) from pain to healing in its embryonic form. What happened after the women who were healing reached the point of perceiving 'trying' to be the 'ideal woman' and 'failing' to be the 'ideal woman' as identical?

When freed from the futile pursuit of 'trying' and 'failing,' and when the core BPP of 'exposing the fiction' comes into effect, they are empowered to leave the cultural roadway. They begin to explore new paths that take them through land which they are free to explore and claim as their own.

Connecting and Breaking the Silence

How did the healing women manage to reach and honour their inner selves? They say that their first glimpse of resolution occurred when they broke the silence surrounding their premenstrual pain and talked with other women. This connection with other women is the deep connecting from the inside-out, which Miller (1988) describes as essential to women's sense of health and well-being.

Without connections, Miller (1988) and Surrey (1985) describe women as experiencing the fear and pain of isolation. In the resolution phase of their stories, the women who are healing tell of feeling powerful relief as they discover that other women share a similar experience. They speak of feeling a special kind of closeness towards the other women with whom they broke the silence. They recount

> Somehow, I didn't feel alone anymore. I didn't feel like a freak and it was really funny but even though I didn't know her very well, I feel like we had a deep inner relationship. It was like I could see inside her and she could see inside me.

This kind of connectedness, a reaching out to other women from inside themselves, is described by the healing women as freeing them from the terrifying trap of being alone, feeling crazy, and being paralyzed.

The feeling of being the only woman who experiences such frightening feelings begins to ebb away. The women describe this ebbing away of fear and isolation as coming from inside of themselves and find it very different, and much more powerful than when outside experts assured them that many women experience 'PMS.'

Connecting, as a major signpost of the women's healing journey, is the process of strengthening the inner sense of self by sharing in the collective voice of women. How do the healing women make this connection? By 'breaking the silence,' and perceiving that 'trying' and 'failing' to be 'ideal women' are one and the same, these women find the strength to continue 'breaking silence' and connecting with other women.

Why does the realization that 'trying' and 'failing' are one and the same give these women the strength to 'break the silence'/'connect?' The reasons have been charted in the map of the cultural roadway. For all of their lives, these women have believed that if they revealed their 'failing' as 'ideal women,' then rejection, punishment, isolation, and alienation would result. Once they understand that 'trying' and 'failing' are identical, their sense of shame begins to abate. Surely, if this is what has happened to them, other women have endured a similar experience.

They begin, at their own individual pace, to leave behind a life-time of hiding, denying, and secrecy. This, in itself, is healing. They begin to share with other women their experience of premenstrual pain and chaos. Their new knowledge empowers them to sense that other women must have travelled the same agonizing pathway and reached similar enlightenment.

They are ready to make connections. The seed they have carried with them (see Onset of Menstruation, chapter 6) since their introduction to menstruation can now be taken out of hiding and examined in the clear light of their new freedom.

Reexamining the previous map reveals that this seed is symbolic of the young women's sense that menstruation could have, and should have, been filled with deep woman-to-woman connection and celebrated with the joyousness women deserve. This memory of what could have been experienced--via a sense of something wonderful which is hidden just out of reach--this disconnectedness (Miller, 1988) can now be a gift. Knowing what "could have been" (Miller, 1988) gives a signpost of what can still be.

Out of experiencing disconnectedness and a sense of loss at the time of menarche, the healing woman can reach for that which was previously beyond her grasp. The seed leads her to search for appropriate ground for its planting. New ground suitable for its planting is found in the world of women, and a first step in its planting is reaching out and sharing the pain of the premenstrual experience.

Accessing the Primary Self

Making connections, realizing that they are not alone, and gaining strength from the voices of other women, empower the healing women to begin the dual process of knowing who they are and believing in themselves. They are now safe to begin exploring, discovering, and reclaiming their Primary Self.

The women who are healing recount that the same activities (i.e., eliminating caffeine, regular exercise) did not alleviate premenstrual pain prior to their own belief that they were entitled to meet their own needs for themselves. When they attempted these activities in the belief they must do something so that their families did not suffer, the strategies did not stop their pain. This is very much the experience referred to by Gilligan (1986) when she refers to "Radical Rethinking of the Old Value System"

> ...when the distinction between helping and pleasing, frees the activity of taking care, from the wish for approval by others, the ethic of responsibility can become a self-chosen anchor of personal integrity and strength. (p.171)

The Journey Into Women's World

The women who tell the story of healing speak of finally feeling free to find out who they are, rather than being what others think they should be. They tell of feelings of empowerment as they discover that it is their right to spend time on their own needs. Appropriately, time spent on their own needs--jogging, walking, being alone, resting, meditating, making dietary changes, and talking with other women--has a healing effect on their premenstrual experience.

Where The Pathway Leads

Where does the pathway of their journey into a women's world take the healing women? First, they share their premenstrual experiences with other individual women. However, this is a different sort of sharing than the previous hidden world of furtive secrets that had to be kept between women to protect them from the patriarchal aspects of their cultural context.

This sharing and connection leads the women to explore further. Having already talked with other women individually, they are strengthened and begin to talk with other women in group meetings. For some women, the group is an informal one, for others, it is a feminist group or a 'PMS' support group of feminist orientation.

It should be clear that there is no rigid, linear progression here. An initial group setting appears to be a starting point; from it the women choose to pursue varied pathways to healing. It must be understood that group work was not limited to 'PMS' workshops, and the women speak of healing via seminars and workshops pertaining to many women's issues.

Connecting with feminist therapists. At some point, all of the healing women accelerate the healing process by connecting with feminist therapists. The feminist therapists assist women to retrace their own life experience through the context of the cultural terrain. They empower women to explore the ground of the rich potential of their own lives in the context of the world of women.

> I took a leave from my job and then I started going to workshops. I started doing things that I wanted to do for me. I went to Vancouver to talk with the Women at the Vancouver Health Collective and it felt wonderful to be there with those women. I made long distance calls to Toronto and to other places where they had

> women-based, self-help centers and really talked with women there.
>
> It was really funny, because I had tried to change my diet before when I first began to experience this, but something changed after I had stopped trying to look after everyone in my family all of the time. Over the course of a couple of months, it just seemed like everything had flipped. Diet and exercise began to make a difference; I have been meditating for a long time, but now there is something different about it, I don't really understand what is happening, except that I feel different now.

Strengthened on the newly-acquired ground of women's world, empowered by the feminist healers' guidance, the healing women cherish the new gift of response-ability and continue in diverse ways to reclaim, honour and value the 'primary self.'

8. DISCUSSION

I have described the experience of women struggling in the grips of premenstrual pain through the metaphors of a map and a journey. A map of their travels was offered, and a legend explaining the theoretical processes occurring throughout was provided. Just as the Theory of women's premenstrual pain is grounded in the context of their culture, the discussion of the Theory itself is grounded in the context of the menstrual cycle literature.

Map of the Discussion Chapter

The reader is offered the following map of the Discussion chapter. First, an explanation of the detours I have taken to protect the integrity of the women whose journey I traced, will be provided. Next, the literature discussing the current menstrual cycle research will be re-examined in light of the Theory.

It is appropriate that the route chosen by me to trace the route from Theory to Discussion is strikingly parallel to the route followed by the women whose story I have told. Like the women, I have made detours: these detours are essential to maintain the integrity of the women's story, the Theory, and its Discussion. The reader is offered a very simple map of the detours taken both in the Theory and their implications for the Discussion.

The First Detour

The first detour was the inclusion of feminist research to substantiate the processes described in the body of the Theory chapter. In Grounded Theory research, the discussion and support from the literature is usually reserved for the Discussion chapter. Unusual though this may be, it is necessary in order to avoid further injuring women by isolating their actual experience as explained by a new theory, from the body of research that supports it.

Historically, this separation has had the effect of cutting off feminist researchers from the very research that supports and strengthens their work. Furthermore, it has made the task of feminist healers more arduous: unifying the new with the already known becomes one more burden they must assume before getting on with the critical work of healing.

The Second Detour

While the first detour occurred in the Theory chapter, the second detour takes place in this Discussion chapter itself. The reader is asked to examine the Western cultural context. Once the reader has viewed the cultural context from the women's experience, it is time to discuss, briefly, the implications of living in such a culture.

The Cultural Context

The context for women's life experience is a society that still retains patriarchal influence: power and dominance are, at least partially, based on gender and assigned to males before, birth. The society is "organized in terms of men's experience, how they define and elaborate on their experience, and this elaboration is called "cultural knowledge" (Miller, 1983, p.2).

Thus, the male culture becomes the model for normality: anything that is different is labelled as deviant or not normal. Furthermore, the ideas, rules and beliefs of this dominant culture are both predetermined and rigidly fixed. What women are told to think, what they are told to feel, how they are told to feel it, and, ultimately, how they are told to behave, are all aspects of women's lives that are regulated and enforced by the patriarchal aspects of the cultural context. Women are permitted to act only within a rigidly prescribed sphere--'trying' and 'failing to be the 'ideal woman.'

Merely because this sphere limits women does not mean, however, that women do not face tremendous expectations. Quite the contrary, the cultural rules demand that women fit themselves into an ideal--the 'ideal woman' as needed by the culture. It is ironic that while the subservient role is so limited and proscribed, it nevertheless places an incredibly heavy set of expectations upon women: living up to the image of the 'ideal woman' is an onerous task. For the Women in this study, the role of the 'ideal woman' is synonymous with 'Failing.' The overwhelming sense of failure inevitably caused them to 'lose access to the primary self.' Thus, ambivalence and paralysis resulted.

It is almost impossible to create the tremendous energy and ingenuity required to be the 'ideal woman,' and at the same time be forced to limit oneself to the narrow range of expression allowed women within this cultural context. Where do energy, ingenuity and creativity go when they cannot be expressed and utilized fully by women, but must be dammed up or channeled into the narrow outlets permitted? Ultimately, the dam must burst; the channels flood.

The anger and rage experienced premenstrually are consequences of the dam bursting. The pent-up emotions created by 'trying' and 'failing' to be the culturally-delineated 'ideal woman' can only be expressed--by some women--premenstrually. However, because of the ambivalence caused by 'trying' to be the 'ideal woman,' anxiety and guilt over feeling such nonideal emotions as anger and rage may result. Feelings of 'failing' and anger are emotions frequently expressed by women who tell their story of severe premenstrual changes.

Women are left in a "subservient relationship of permanent unequal status and power" (Gilligan, 1982, p.169). A primary implication of living in a patriarchal culture is that the culture does not attend to women's experiences, and specifically denies them (Miller, 1986). Women are prevented from learning and exploring their own experiences: they are only permitted to view their lives through the lens of male experience. Women are only allowed to describe their own experience through the use of male language: male language best describes male experience.

Many women must continue to support a system destructive to their own needs, because of economic and emotional necessity. Subordinates do not believe in their own ability to create change, and so remain in permanent subvervience (Miller, 1986). The helplessness felt by many of the women experiencing severe premenstrual changes is at least a partial consequence of their inability to believe in their own potential to create changes.

It follows that "subordinates are described in terms of, and encouraged to develop personal, psychological characteristics pleasing to the dominant group" (Miller, 1986, p.7). The use of male language damages women in their attempts to define a personal sense of self ('accessing the primary self'). For example, a woman whose cervix does not dilate to 10 centimeters during labour is described as 'failing to progress.' How does a woman who as a consequence of cervical dilation of less than 10 centimeters, experiences a Caesarean section, describe this? The only language available to her (male-dominated, obstetrical language) forces her to say that she has 'failed to progress.'

Historically, psychological literature was constructed by men, using male language. The decision by the American Psychiatric Association (APA) to re-name 'PMS' as Late Luteal Phase Dysphoric Disorder, conveniently shortened to LLPDD is a prime example. One shudders at the humiliation of a woman who feels as if she is already admitting failure, when she is further humiliated by being informed that she does not have 'PMS;' she has LLPDD. This name has the effect of overwhelming and impressing upon her the necessity of succumbing to superior medical wisdom. Obviously, the struggle to empower women to define their own experience is far from over.

Carla McKague (1989), a Toronto lawyer and patient advocate, has the following comments to make of her experience in attempting to help women get out of psychiatric institutions:

> Sometimes, if I have a client who's desperate to get out, I'll ask her how far she is willing to go. ... If they say 'anything', I tell them to get rid of their jeans, get their hair done, and start flirting with the male ward attendant....(McKague, 1989)

McKague (1989) adds that women who do this and "say how much they miss their children and want to go home to do embroidery," are more likely to escape from the institution.

Healthy development for both males and females is described as attaining autonomy, independence, and separation. Women are subsequently viewed as being unhealthy when they do not attain these characteristics. Having said that women, in order to be healthy, must exhibit many of the same characteristics as men, their cultural system ensures that they cannot develop these characteristics and condemns women who make such attempts as unfeminine. Logically, ambivalence and paralysis are results of this paradox.

In addition to demanding that women demonstrate autonomy, independence, and separation, it is also required that they possess the same apparent lack of emotional intensity as men. The task of being an 'ideal woman' is further complicated by the additional expectations that a patriarchal culture demands of its female members. Bem's Sex Roles Inventory lists the most desirable feminine qualities, and perusal of the list would daunt Florence Nightingale, Joan of Arc, or any other aspiring saint. Caplan cites further myths about women:

> females are naturally tidy, careful, physically graceful, and inert, don't wish to venture far from home; females are emotionally needy and will drain others around them if allowed free reign and females are endlessly nurturant. (Caplan, 1981, p.23)

With such an incredible list of rigidly-defined qualities required by the culture, it is not surprising that many women experiencing severe premenstrual changes feel a deep sense of personal 'failing.' First, they believe that they are incapable of being the 'ideal woman.' Next, their experience (of severe premenstrual changes) confirms this belief. Finally, their internalized beliefs about personal 'failing' are confirmed once again, by their inability to heal themselves, or for "experts" to heal them.

All of the characteristics that are defined (by a patriarchal culture) as indications of a woman having a healthy sense of self are centered around caring for others, not caring for self. Women experiencing severe premenstrual changes, need desperately to care for self, but do not know how. After all, a patriarchally influenced culture is designed so that the 'ideal woman' is trained to take care of everyone else: for her to need self-care is an admission of 'Failing.' Not only are women deliberately not taught to know how to take care of their own needs, but they also feel guilty for having such needs in the first place.

Women, in their care-taking role, are assigned the task of teaching the children the values and behaviors culturally prescribed. The cultural insistence that mothers raise their daughters to be 'ideal women' places a mother in a serious dilemma. Most women know from their own experience, consciously or otherwise, what their daughters need to do, and not do, in order to survive.

Attempting to improve their daughters' chances for emotional survival, mothers instill the necessary lessons of how to be an 'ideal woman' even more stringently than they themselves were taught. Therefore, they teach their daughters to behave as 'good women,' nurturing of others and self sacrificing (Caplan, 1981). Thus the conditions conducive to severe premenstrual changes may take root if the daughters overlearn and overinternalize the overteaching of the mothers. Again, it must be reiterated that the recognition of this tragic pattern is not mother-blaming.

What else are mothers--in such a cultural context--allowed to do? Ironically, women have been so disempowered that the only protection left is to ensure that their much loved daughters are equipped to survive by knowing the absolute rules of a deadly game--a game in which they are arbitrarily enrolled by gender, not by choice.

In order to survive, (literally in some experiences), many women are forced to be this 'normal' or 'ideal woman,' deferring

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to the judgement of men about what is good and bad, healthy and unhealthy, valuable and not valuable (Gilligan, 1982, p.69). Having been well trained to defer to men, women experiencing severe premenstrual changes may spend years seeking expert advice from the male dominated, male determined professions. The frequent 'Failing' of this prolonged search to bring relief adds to the internalized sense of 'Failing' and hopelessness.

Revisiting the Literature of Menstrual Cycle Research

What is 'PMS?'

The Psychiatric Perspective

The psychiatric perspective emerges out of the biomedical model, and thus the inconsistencies and inaccuracies plaguing the biomedical field are brought to the psychiatric domain as well. Therefore, not only is the psychiatric perspective based on the shaky domain created by the methodological errors of the biomedical model, it also brings with it the biomedical belief that women's emotional experience of premenstrual pain is a demonstration of a pathology. Hence, from this perspective, it is interesting to note that although these experts are neither sure of what they are treating, nor how it should be treated, they are clear on one issue: they are faced with a pathology and pathological women. Thus, treatment to arrest and/or contain the pathology is essential: drugs, electroshock therapy, and occasionally hysterectomy (all accompanied with appropriate traditional psychotherapy) are justified in order to cure this female malfunction. Tragically, any or all of the above have the effect for which they were designed (at least if the practitioner is successful). Women who respond well to treatment stop being non-Ideal Women and get back on the road to being Ideal Women. On occasion, it may be necessary to re-adjust their dosage of tranquilizers, antidepressants, or progesterone. Additional sessions of traditional psychotherapy may be required. In some especially difficult-to-treat cases, the clinician may be forced to re-evaluate the original diagnosis of Late Luteal Phase Dysphoric Disorder. Perhaps the patient does not have LLPDD after all.

> It is not uncommon for women with other mental disorders, such as mood disorders or anxiety disorders, to experience premenstrual exacerbations of these disorders .... The cause and treatment of premenstrually exacerbated disorders may well be different from those of disturbances that are limited to the premenstrual phase. This criterion indicates that the diagnosis is not given if the symptoms are only an exacerbation of another disorder. (Spitzer, Severino, Williams & Parry, 1989, p.12)

This is a tragedy for women, unless they are fortunate enough to encounter either skilled feminist healers, or male healers who are sensitive to feminist issues. The ensuing treatment--be it for 'PMS' or the diagnosis of yet another disorder, should the 'PMS' prove intractable--prevents their Accessing the Primary Self. The terrible rage that is one of the consequences of their experience of the premenstrum and which is intrinsic to their perception that 'trying' and 'failing' are one in the same, are suppressed by the traditional psychiatric approach.

McKague (1989) states that aggression is considered so deviant in women that it is likely to get a woman back in a psychiatric ward. When women's rage over 'trying and failing' is suppressed, they are prevented from ever reaching the understanding that rage can be a healthy response to an unhealthy context (Caplan, 1981; Gilligan, 1982; Miller, 1986).

This suppression has the effect of thwarting women's ability to reach through their rage, understand the futility of attempting the impossible ('trying and failing'), and re-directing their energy toward healing by exploring who they are and what they want to be. Yet another ramification is that they stay stuck: the effects of mind-numbing drugs make it more difficult to put their life experience in context. Reaching feminist healers may be thwarted as well: drugs which alter both the body and the mind can occlude even the perception that healing from the inside-out is either possible, or desirable.

What Causes 'PMS'?

Psychosocial Theories

The psychosocial theories that examine the issue of women's pain in the premenstrum target the areas of social stress, social support, and expectations and stereotypic beliefs about menstruation. As these theories are sociological in nature and thus, focus on women in relationship to others, they form a useful background of knowledge, both in terms of the narrator's Theory and the general body of feminist research. Why?

The psychosocial theory that targets social stress--although supported only by limited research--suggests that women experience more chronic social stress than men and that the female body is especially sensitive to environmental changes and stressors. Does this mean that women have a weaker physiology than men by nature of their reproductive system? This does not appear to be what this theory suggests. Men may express different reactions to psychological stressors--heart disease is only one example.

Thus, according to the psychosocial model, women may experience and express their reactions to the severe social stress they experience (by the very fact of being women) in many different ways. The experience of severe premenstrual changes is one of them.

The psychosocial model also focuses on the issue of women and social support. In this model, there is a strong theoretical assertion that both casual, less intimate friends, as well as intimates afford protection against illness for women. Again the narrator's theory offers a specific feminist refinement of this general philosophy. Miller's (1988) connectedness as integrated throughout this Theory, deals specifically with why women become ill without connection to others and may begin healing within connection.

Another group of psychosocial theories deals with the relationship between severe premenstrual pain and cultural expectations and stereotypic beliefs. Horney's (1967) insistence that premenstrual tension is a result of conflicts involving the wish for a child is refuted by more recent research, and may well be an unfortunate example of a genuine attempt to examine women's issues that is grounded in the context of woman-blaming patriarchal training. It is to be hoped that the growing body of feminist research collected, cherished, and put to healing work by feminist therapists/other healers will offer freedom from the stricture of traditional patriarchal methods.

However, the large body of the psychosocial research focuses on situational factors and negative cultural bias towards the menstrual cycle. The consensus appears to be that women's life experience has a strong effect on the premenstrual experience. Much of this research maintains, as well, that negative beliefs about menstruation have a debilitating effect on women during the premenstrum. Again, this body of research offers a useful background that supports the feminist research in the narrator's theory and elsewhere. The Theory advanced by this narrator both hones in on the specifics of women's situational experience and the negative introduction to menstruation, while at the same time, integrating both into the cultural context.

A gained advantage of the feminist approach as advocated by the narrator, is that it does not ignore the issue of physical healing, but rather suggests that healing from the outside-in is more effective once healing from the inside-out has commenced. Women who are empowered can negotiate (particularly if assisted by feminist therapists) the medical world in safety and draw from it that which is of assistance to their own healing.

Montgomery's map--another metaphor of healing. Montgomery's (1982) phenomenological study of the premenstrum maps the journey of seven American women with such profound richness and such respectful insight towards women, that it deserves a special place in the revisiting of the literature. Montgomery's (1982) research reveals that during the premenstrum, women experience varying alterations in relation to body, self, world, and time. This altered relation to body, self, and world is an apparent paradox: "a being more connected to, and a being more estranged from, both pleasurable and distressing" (Montgomery, 1982, p.48).

One of Montgomery's themes is that the premenstrual woman moves away "from the everyday objectivity of the outside work/ social world, which feels burdensomely demanding" (Montgomery, 1982, p.49). The premenstrual woman experiences " a sense of estrangement from self and world" (p.50). This dovetails with the theory offered by the narrator.

In the Theory traced by the narrator, the premenstrum is the time when women begin the process of estranging themselves from the enforced self of 'ideal womanhood' that the world imposed upon them in their attempt to be 'ideal woman.' Thus, the demands of this world--"the everyday objectivity of the outside work/social world" (Montgomery, 1982, p.49)--is indeed "burdensomely demanding" (p.49). The outside world is "burdensomely demanding" because it interferes with women's attempts to Access the Primary Self by going inside, and therefore, healing from the inside-out.

Montgomery (1982) next explores the theme of the premenstrual woman's need to receive "empathetic understanding from an intimate other" which "reinstates a feeling of well-being" (p.49). She refers to this as "relatedness" and reports that if relatedness is absent, the premenstrual woman is "intensely reactive" (p.49). This is clearly the attempt to find connectedness (Miller, 1988) and, hence, re-access the 'primary self,' as described in my theory.

Montgomery's (1982) next theme accords with my theory of the premenstrum as offered here.

> The premenstrum punctuates the flow of time. This encourages a seeing ahead and a looking back, as old conflicts, behaviors, and identifications are re-experienced and future developments anticipated. (p.49).

The women whose journey through the premenstrum has been traced here confront the context and conditions both of being born into society retaining patriarchal influences, and into dysfunctional families. They also look back, both to understand their 'failing' and to search for the 'primary self.'

In my theory, the future developments that Montgomery (1982) reports premenstrual women as anticipating, may represent various unrealized possibilities. For women in the intense throes of premenstrual pain, one longed-for future development is 'trying' and succeeding as 'ideal women.' For others, who are further along in their journey, the realized possibility is that 'trying and failing' are one. For still others, the anticipated, but unrealized possibility is how to Access the

Primary Self by making connections, both internal and external. These women are in the embryonic stages of healing, have realized much of the above, but are still between the two worlds. Consequently, for them an anticipated but unrealized reality, is exploring the rich potential of their own lives and charting their own route through the new terrain of both the 'primary self,' and the world of women.

The Feminist Perspective

A fundamental tenet of the feminist perspective is that women can accurately report their experience, and that the feminist perspective affirms the accuracy, value, and integrity of the experience as the women live it. The feminist perspective immediately commences the process of empowerment by validating the courage required of women in order to report their life experience. In the case of women who cannot, for whatever reasons, make direct, personal connection with Feminist therapists, feminist literature validates their courage in seeking self-knowledge ('accessing the primary self') via whatever means are available.

The next fundamental tenet of the feminist perspective is that it is crucial to educate women about the context superimposed on their lives in order to eradicate the horrifying spectre of self-blame which so often haunts women in this culture. It is hoped that as both feminist research and feminist healers flourish, that feminist healers (who are critically over-worked and hampered by the dearth of empowering research) will finally have the time to work with those male therapists who are sensitive and ready to contribute to women's healing in a richer way.

Feminist therapy is not a specific method of therapy, but a value system, and thus, enables feminist therapists to draw upon many therapeutic means in order to assist clients in accessing their inner resources. One of the major tenets of feminist therapy is that it is important to minimize the power differential of the therapeutic relationship.

The major components of feminist therapy are:

1. The therapist is aware of her values and makes them explicit in her work with clients.

2. A belief that all roles are open to all people:
    -rejects the constrictive female role as a healthy model for women,
    -accepts the assumption that traditional female sex roles will generate emotional conflict.

3. The feminist therapist explores the contradictions in the prescribed social roles for women.

4. The feminist therapist maintains the position that "the person is political." The traditional therapist listens for pathology. The feminist therapist listens for the conversation between the personal and the political in women's stories.

5. The therapeutic relationship in feminist therapy works on demystifying the power relationship:
    -the egalitarian relationship is one of the hallmarks of feminist therapy;
    -the client is regarded as her own best expert on herself and her experience.

In addition,

1. Anger is a legitimate response to certain situations, not a sign of pathology but a potential source of constructive change.

> 2. The feminist therapist acknowledges that therapy alone is not the only "cure-all" and considers other focuses for growth.
>
> 3. The feminist therapist explores women's issues.
>
> 4. The feminist therapist encourages self-nurturance of women.
>
> 5. The feminist therapist encourages women to assume personal power.
>
> 6. Working with women in groups has always been seen as a positive and effective way of working with women, as a means to help overcome the sense of isolation and alienation from selves and others.
>
> 7. The feminist therapist believes therapy means change, not adjustment. (Liburd, 1989)

Self-affirmation is approached via whatever route is appropriate to the needs of the individual client, within the value system of feminist therapy: the therapeutic method is chosen to fit with the client, not imposed upon her/him. Five of the six women who were either healing, or approaching the embryonic stages, had experienced connections with feminism. For some of the women, the connection was made through reading feminist literature. For others, connectedness was either attained or enhanced by therapy with feminist healers. For all of the healing women, regardless of where they were in their healing process, the sense that they had a right to a self of their own and the belief that they had a further right to access that self, was beginning to emerge at the time they related their experience to me. This is directly supported by the feminist perspective.

Only when women can discover who they are, rather than who they are told they must be, can they begin to heal from the inside-out.

A Poem of Welcome

It is a full moon and we are by the sea.
The tide is so high it laps the lip of grass.

What's this? you say over a bright stain of blood.
We both know. All the pulls and tugs aligned.

and you stepped to the woman-side
shedding your childhood as simply as a robe.

You must be the daughter of the moon, I say,
and hugging, we buy you small silver hoops

earrings that hold, under your yellow hair,
the secret of who you really are.

Well then, by this single act of the moon,
by this inevitable blooming

you enter our tribe. We welcome you,
one of the youngest, with streamers of pride

and offer our history for strength, our berries for gifts
our force of gravity, love of pleasure, our myths.

Judith W. Steinbergh (cited in Taylor, 1988, p.21)

Alternate Maps

Introduction

Different maps can be used to arrive at the same destination. Therefore, sometimes a new map can provide a fresh perspective. Alternatively, there can be many routes to the same destination.

The purpose of this section is to show how my theory both adds insight to, and parallels other, established psychological and anthropological theories. Inherent in the very nature of qualitative data is the possibility that the data itself can be interpreted in a variety of ways. One of the requirements of Grounded Theory research (in order to establish validity) is that another researcher would observe the same data. However, Grounded Theory does not require that another researcher observing the same data would necessarily arrive at the same conclusions about the suggested relations between the categories. As Currie (1988) states

> The purpose of data collection is the generation of hypotheses which concern suggested relations between the categories. At this point the researcher is no longer a passive receiver of impressions, but begins to verify these hypotheses through comparisons of groups. (p.236)

This is a crucial point to the understanding of the difference between Grounded Theory and other research methods. Why? It is here that the 'real life' nature of the field work emphasized by Glaser and Strauss (1967) emerges.

This 'real life' field work emerges from the comparison of groups. From the resultant accumulation of interrelationships, the core of the theory emerges. Moreover, as Currie (1988) states

> Furthermore, the 'unstructured' nature of the investigation acknowledges that researchers are likely to develop insights about theoretical issues during data collection ... (p.236)

Currie (1988) expands on Grounded Theory by noting that Glaser and Strauss (1967) identify informed 'hunches' as frequent precursors to major scientific discoveries. The source of such hunches are

> The sensitive insights gained via the researcher's intimate associations with--rather than distance from

> --the data ... crucial insights may come from *the researcher's personal experiences prior to or outside of the research*. (Currie, 1988, p.236)

The validity accorded the researcher's insights, hunches, and 'personal experience prior to or outside of the research' help to explain why Grounded Theory maintains that different researchers must observe what I observed, but not necessarily interpret the data in the same way.

A Brief Strategic Psychotherapeutic Map

The work of Watzlawick, Weakland and Fisch (*Change: Principles of Problem Formation and Resolution*, 1974) offers an alternate map that pursues a different route to demonstrate how difficulties arising as a result of life's experiences can escalate into major problems that prevent healthy change.

Watzlawick et. al., (1974) write from a psychological perspective known as 'Brief Strategic Psychotherapy.' Their work is non-feminist in that it is written from a generic perspective and does not involve either feminist language or ideology. Nevertheless, their theory of change--based on Brief Strategic Psychotherapy--corresponds to the theory explaining the behavioral patterns observed within this thesis.

Watzlawick et. al., (1974) discuss 'first' and 'second' order change and the relationship of these levels of change to difficulties and problems. They define 'first order change' as the achievement of a desired state by applying the opposite of what produced the effect. The analogy of a thermostat is used--if a room is cold, the appropriate 'common-sense' response is to turn up the heat by adjusting the thermostat (hot versus cold).

Next, Watzlawick et. al., (1974) suggest that real-life presents many difficulties which, although unpleasant at the time, are neither intrinsically damaging, nor chronically destructive. However, if the individual experiencing the difficulty responds by utilizing what appears to be the 'common-sense' solutions, (i.e., first order changes) the situation accelerates and escalates. For example, if a woman experiences fatigue as part of her premenstrum, she may 'turn up the thermostat' by deciding that her fatigue is 'PMS' and putting herself on a rigorous exercise regime to counteract her fatigue. According to Watzlawick et. al., (1974) this move to what they term 'first order change' has the effect of escalating the difficulty to the level of a problem. They define problem as

> ... meaning impasses, deadlocks, or knots which are created and maintained through the mishandling of a difficulty. (Watzlawick et. al., 1974, p.39)

In the case of the woman, the difficulty of facing fatigue during the premenstrual time is escalated to the level of a problem--exhaustion, (as a result of the exercise regimen). At this point, Strategic Psychotherapy suggests that the individual may further increase and accelerate the problem by attempting 'more of the same' solutions.

> More of the same can lead to dietary changes, alterations in scheduling, medication, and consequent drug dependence. Each of these steps, rather than solving the problem, intensifies it. (Watzlawick et. al., 1974, p.35)

For the woman who has identified her difficulty with premenstrual fatigue as 'PMS,' and experienced the failure of her exercise regimen, the next step in combating the resultant exhaustion is to try harder. She attempts 'more of the same' and exercises even longer and harder. This is the identical process utilized by the women in the story. When they experience changes --emotional and/or physical--prior to the onset of menstruation, they respond by employing the strategies discussed in chapter 4. When the strategies fail, they either try harder, by working harder at the same strategy, or by moving to yet another strategy.

> If I just tried harder this month to do everything right, things would be better. If I just made sure to do my yoga all the time then I wouldn't be in such bad shape.
>
> It's my fault the 'PMS' diet didn't work. I still let myself drink a couple of cups of coffee some days, and I did eat a chocolate bar. Next month I have to cut out coffee entirely and just stop eating any sweets.

The more they perceive that they are failing (the strategies are failing), the harder they try. The combination of 'failing' and 'trying' harder has exactly the effect discussed by Watzlawick et. al.,: while the situation itself remains similar or identical, the suffering entailed increases. Furthermore, Watzlawick et. al., (1974) state

> This appears as a contradiction: on one hand, the problem is presented as remaining unchanged, while on the other hand, it is described as getting worse. (p.32)

In the case of women experiencing so-called 'PMS' the above may explain the massive confusion surrounding the sincere attempts on the part of the biomedical and psychiatric community to arrive at even a clear, consistent diagnostic definition of the 'syndrome.'

The discrepancy existing between women's experiential description of severe premenstrual changes and the diagnostic requirements for what the APA is calling Late Luteal Phase Dysphoric Disorder has fuelled a painful and bitter dispute. A partial explanation may well be found in the above quote.

When first order change fails to effect the desired change, what happens next? Strategic psychotherapists postulate that not only has the presenting difficulty been escalated from the original level (of difficulty) to the level of a problem, but may actually have become the problem itself. At this point, the problem assumes such immense dimensions that it can take over the individual's life.

This is what happens to the women when the strategies (or first order changes) continue to fail, and their experience of the premenstrum escalates into feelings of anger turning into rage, next of acting crazy, then of feeling crazy, and ultimately of being crazy. These Consequences (as discussed in chapter 5 and 6) take over the women's lives exactly as the Strategic psychotherapists describe the results of failed first order changes.

Watzlawick et. al., (1974) describe what they name 'Utopian Syndrome' as the belief that life should be perfect, and that the individual can lead a life of happiness, free of difficulty. They define the utopian individual as "one who sees a solution when there is none" (p.47). It is the 'Utopian Syndrome' itself that leads to the belief that difficulties are not a part of ordinary, everyday life. Consequently, individuals who internalize the Utopian Syndrome believe solutions must exist even when there are none. Such individuals have internalized a belief that life should never be difficult, and therefore, believe that there must be ways of eliminating all difficulties.

If the individuals fail to eliminate difficulties, they experience a devastating sense of personal inadequacy: "the unattainability of the goal is not likely to be blamed on its utopian nature, but on one's ineptitude" (Watzlawick, et. al., 1974, p.48).

The parallel to the women who participated in this research is striking. Their belief that it was both possible and necessary to be 'ideal women' exemplifies the Utopian Syndrome. Their reaction to 'failing to be ideal women' is exactly as predicted by Strategic Psychotherapists: they believe they are inadequate human beings.

Not only is their reaction to 'failing as ideal women' accurately predicted by Strategic Psychotherapists, but also, so is their response to the suggestion that 'ideal womanhood' is an impossible goal or a fiction. (This response changes as the women begin to heal).

> ... the idea that fault may lie in the premises is unbearable, for the premises are the truth, the reality ... (Watzlawick et. al., 1974, p.54)

This perspective helps to explain why the women continue to expend exhaustive energy attempting to implement strategies that have already been demonstrated as ineffective and even injurious. It is less terrifying to continue the endless series of detours around the impasse of 'PMS' than to abandon, and/or question the belief in 'ideal womanhood.'

Furthermore, it helps to explain why the women's reaction to the continued failure of the strategies is to move to a position of believing that they are crazy. As explained by Strategic Psychotherapists, it is more bearable, for individuals who desperately need the security of their Utopian beliefs, to believe that they are crazy rather than to believe that the safety of the perfect world does not exist.

It may be of assistance in clarifying this point to refresh the reader's memory of the original map: these women have travelled through this set of conditions:

1. being female children in a patriarchal culture;
2. coming from dysfunctional family backgrounds; and
3. experiencing negative introductions to menstruation.

Condition 2 may be particularly responsible for their need to believe in a Utopian existence: the unhappiness of childhood spent in a dysfunctional family might accelerate the need to believe that it is possible, as an adult, to find a world which is always happy, or difficulty-free.

Furthermore, being children of dysfunctional family backgrounds may not only have made them more vulnerable to the internalization of extremely traditional patriarchal values, but it may also have set the stage for their belief that they are crazy. Children from dysfunctional families often believe that they are different, and that they are the cause of the family's difference.

Thus, when the Utopian Syndrome of 'ideal womanhood' is shattered by their severe 'PMS' experience, it is likely that they believe that their childhood difference has escalated into craziness, rather than accepting that 'ideal womanhood' is a myth. After all, 'ideal womanhood' holds forth the promise of success, approbation, and happiness--if only it can be attained. To women who carry with them into adulthood the needs of terrified children--the unmet needs for the safety and protection they deserved and were denied--it is unbearable to believe that this safe haven does not exist.

How is the experience of the women who are in the process of healing explained in terms of Strategic Psychotherapy? In the language of Strategic Psychotherapy, these women experience 'second order change:'

> ... decisive action is applied (wittingly or not) to the attempted solution, specifically to that which is being done to deal with the difficulty--not to the difficulty itself ... (Watzlawick et. al., 1974, p.81)

Second order change alters the focus away from the problem and refocuses attention to the attempted solutions. As the attempted solutions--in the case of these women, the strategies --have become the problem itself, second order change provides a re-focus. Instead of the endless pursuit of strategies and/or the focusing on how they can try harder next month to make the strategies work, second order change does not involve 'more of the same.' Nor is second order change based on apparent common sense, unlike first order change. Second order change

> ... usually appears weird, unexpected, and uncommonsensical; there is a puzzling, paradoxical element in the process of change ... (Watzlawick et. al., 1974, p.82)

Thus, the solution to 'trying and failing' to be the 'ideal woman' is to stop 'trying.' When the women who are beginning to heal stop 'trying,' paradoxically, they begin to feel far more like their own version of Ideal and less like failures. A more specific example is the initial step the healing women recount: breaking the silence and actually revealing the extent of their perceived failure as 'ideal women' does not confirm their own failure. Instead it frees them to focus on who they want to be, rather than adhering to endless strategies that both exhausted them, and confirmed their own sense of failure.

Additionally, as much as these women desperately needed the Utopian Syndrome of 'ideal womanhood,' realizing that 'trying and failing' are one and the same is, paradoxically, not terrifying but instead reduces their fear and frees them of the need to believe in the Fiction of 'ideal womanhood.' Women (in the healing process) who stated that sometimes they felt like they were crazy and that they knew it was ok to feel crazy, no longer experienced the terrifying feelings of rage or dangerous craziness, nor did they have to expend energy on strategies to suppress rage or craziness.

Anthropological Map: 'PMS' As A Culture-Bound Syndrome

Just as it is possible to explain the behavioral processes of the women whose experience is the foundation of this thesis by using the map of Brief Strategic Psychotherapy, it is also possible to use a map rooted in cultural anthropology. Johnson (1987), puts forth the thesis that premenstrual syndrome is a 'culture-bound syndrome.' "Premenstrual Syndrome As a Western Culture-Specific Disorder" (Johnson, 1987) is not only the title of Johnson's work, but also provides a succinct summary of Johnson's explanatory model.

Johnson (1987) bases his explanatory model on the definition advanced by Cassidy, 1982; Ritenbaugh, 1982; and Shwartz, 1985.

> Culture-bound syndromes which involves a constellation of symptoms categorized by a given culture as a disease; the etiology of which symbolizes core meanings and reflects preoccupations of the culture; and the diagnosis and treatment of which are dependent upon culture-specific technology and ideology. (cited in Johnson, 1987)

Johnson (1987) proposes that 'PMS' is another "Western culture-specific disorder" fitting this definition. He further states

> the reality of such syndromes is the result of a negotiation between those who treat it and those who suffer from it, even though symptoms may exist apart from the negotiated reality. (Johnson, 1987, p.338)

Although further discussion of Johnson's (1987) postulate re: symptoms existing 'apart from the negotiated reality' will be discussed in more detail later, a brief parallel is offered here. If Johnson (1987) is correct about the negotiated difference between symptoms and reality, this may help to explain the dispute between women who experience 'PMS' and the diagnostic requirements of 'PMS' as defined by the American Psychiatric Association.

Johnson (1987) also offers an explanation as to why the entire issue of premenstrual syndrome has become intensely controversial, and immensely confusing.

> The failure to describe culture-bound syndromes in our own culture betrays a peculiar ethnocentrism and impedes our full understanding of both these phenomena and their relationships to the cultures in which they exist. (Johnson, 1987, p.338)

Furthermore, Johnson (1987) suggests that ethnocentrism may explain why biomedical investigative researchers have not attempted to study why premenstrual syndrome, as such, is a relatively recent newcomer to Western Culture.

> More assuredly, these investigations (biomedical) have not addressed the important question of why premenstrual syndrome ('PMS') has only appeared in Western industrial cultures in the past two decades, despite the fact that premenstrual symptoms have been recorded in diverse cultures for centuries. Whatever the outcome of Western scientific studies of 'PMS,' the emergence of this syndrome clearly deserves to be examined culturally, and anthropology has much to offer in this regard. (Johnson, 1987, p.346)

Johnson's (1987) plea for the examination of premenstrual syndrome in relationship to its cultural context is supported by the experience of the women participants in this research. The women whose story is the foundation of the narrator's theory may have internalized the most traditional aspects of a patriarchal culture to a degree that intensified its significance. Two of the more probable causes--being children of dysfunctional family background, and experiencing a negative introduction to menstruation--have been discussed previously.

Johnson (1987) discusses many of the major problems surrounding 'PMS' research done by biomedical researchers, and pinpoints what he suggests is a significant omission. Despite the acknowledgement, on the part of respected researchers, of the existence of major problems, and despite a genuine desire on the part of the biomedical professions to clarify the confusion surrounding 'PMS,' there is continued striving to discover the ultimate biological explanation without examining the contributing cultural forces.

Johnson (1987) hypothesizes that this omission is a result of our discomfort about, and our unwillingness to see, culture-bound syndromes in our own culture, although we are quite willing to accept such syndromes in other cultures.

> We strive to discover the biological *reality* of 'PMS,' for example, without examining the cultural forces which are attendant in the *process* of creating that reality. We are willing to see culture-bound syndromes in other cultures when we cannot readily understand their symptom complexes in biomedical terms. Even though there are those who strive to find congruence between bizarre symptom complexes in other cultures and Western biomedical disease entities, there has been an implication that such syndromes are 'not real.' Yet we unquestioningly treat our own problematic syndromes, such as 'PMS,' as 'real,' striving constantly to find physiological correlates of symptoms. (Johnson, 1987, p.347)

Having established the reasons for his postulate that a culture-based explanatory model is crucial to the clarification of the discrepancies surrounding both premenstrual syndrome, and the research about it, Johnson (1987) goes further. He proposes that 'PMS' requires "a symbolic understanding" (Johnson, 1987, p.348). In his opinion, it is a culture-specific disorder symbolic of the immense change in the status and roles of women in the cultures where it is acknowledged.

According to his explanatory model, 'PMS' is symbolic of the role conflict women experience in Western industrial culture at a time when they are expected to be both productive and reproductive.

> ... our culture is a role conflict in which they are expected to be both productive and reproductive: to have both careers and families. In fact, the 'messages' are highly ambiguous, with women placed in a cultural double-bind in which expectations for doing either or both are equally conflict laden ... (Johnson, 1987, p.369)

Thus, in Johnson's (1987) model, 'PMS' resolves the role conflict of productivity and reproduction by denying the possibility of each "simultaneously and symbolically" (Johnson, 1987, p.349). A menstruating woman demonstrates potential fertility, but is non-pregnant. At the same time, according to Johnson (1987), her incapacitating 'illness' lessens normal 'work role expectations.'

Blaming as this statement (of Johnson's) sounds, he states that premenstrual syndrome is a cultural 'safety valve' connected with the nebulous, conflicting roles of women in Western industrial societies.

> Through 'PMS,' Western culture translates the ambiguous and conflicted status of woman into a standardized cultural idiom which makes her position 'meaningful.' It is a symbolic cultural 'safety valve' which (sic) recognizes the need for women to simultaneously turn away from either alternative role demand. (Johnson, 1987, p.349)

He offers as substantiation his content analysis of advertisement and articles about 'PMS' 'remedies' in popular women's magazines. None of the articles or advertisements pictorially depict women in either business settings, nor are children or men in evidence. In some cases, blatantly ambiguous settings are shown, with one woman portrayed as talking from a phone booth, and in another a woman is dressed in a business suit combined with a long string of pearls.

'PMS' is depicted in ambiguous settings because it symbolizes the role of women in Western industrial society. This role is in itself, ambiguous. On one hand, it is recognized that Western women's roles have changed dramatically in the last two decades: not only have their work roles become essential to the society, but their entire status is changing. On the other hand, Western women are still expected--and expect of themselves--to fill a reproductive role.

This ambiguity is increased by the social reality that while their roles are 'changing,' the process is one of transition and, as such, is neither complete, nor clear. This may help to explain why there is currently a gap when one searches the academic literature for a definition of patriarchy that is relevant to the latter half of the 20th century.

Definitions are found either at one end of the spectrum, or the other, but there appears to be nothing in between. At one end, definitions of the term make reference to father-dominated tribes. On the other hand, searches for definitions that are appropriate to the cultural context of today--one that has patriarchal roots not yet completely abandoned, but in which women certainly experience a changed role--lead to feminist literature. This is not to imply any criticism of feminist literature: the point here is that there appears to be no applicable definition available elsewhere.

If Johnson (1987) is correct, this dearth results from the confusion of Western society itself about the changing status quo. How is a culture to define that which is still in the process of changing, particularly when it is unknown and difficult to predict where and to what the change will lead? Definitions are not predictions.

The significance of confusion and ambiguity in women's current roles is integral to Johnson's (1987) explanation of 'PMS' as a culture-bound syndrome. In Johnson's (1987) view, women were previously considered to be "'delicate,' 'fragile,' 'emotional,' 'unstable,' or 'hysterical' (from the Greek _hysteria_, meaning womb)" (Johnson, 1987, p.350). Hence, not only were women regarded as incapable of assuming masculine, public roles, but they were also forced to experience menstruation and its symptoms as part of their 'curse' "without benefit of general cultural sanction" (Johnson, 1987, p.350).

However, women's work roles have now become an essential part of production and thus, the resultant "structural alterations" both demand and necessitate liberation from these restrictions. The mechanism used is premenstrual syndrome:

> 'PMS' provides a basis for a cultural realignment in sex roles by encapsulating the cultural stereotype of women, defining women as potentially irresponsible only some of the time, providing a legitimate label for a

> previously deviant status, and asserting that irrational thoughts and incapacitating physical symptoms relate to a medically treatable entity. By defining women as potentially 'in control' of heretofore devalued constitutional characteristics, 'PMS' 'negotiates' access to power in a way which indirectly legitimates the changing status of women without directly threatening or destroying the structural status quo. (Johnson, 1987, p.350)

Thus, in Johnson's (1987) model, 'PMS' is a symbolic entity that reflects the changing cultural context: women's changing status is recognized, but at the same time the "structural status quo" of the overall culture is not thrown into chaos. Women are equal or 'the same as' most of the month: when they are not equal--during the premenstrum--this is not because the culture denies their equality, but because they are 'ill.' Therefore, the culture is absolved of responsibility concerning women 's inequality: women are unequal because they are 'ill' part of the time.

However, an indication of women's growing power and status is that women are no longer blamed for 'the curse,' nor are they required to hide it. In recognition of their essential role in the working world and their growing status, women are exonerated from blame: they are viewed as legitimately experiencing a genuine 'medical condition' that is viewed as a medically treated entity. Society offers women a trade-off. Women, exhausted by dual role expectations, are allowed to be 'sick' and experience 'PMS.' The culture can retain many of its traditional roles about women.

This is what Johnson (1987) means when he refers to 'PMS' as a culture-bound syndrome and states that such syndromes are negotiated among the members of a culture. In the case of 'PMS' the following analogy appears evident: it currently offers Western culture a form of no-fault insurance. Everyone involved receives some form of compensation, and no one is blamed, or at least not overtly. It is important to be aware that this model does not deny the existence of physical, emotional, psychological, or even psychiatric symptoms. However, it is the way in which the symptoms are viewed and treated by both the individual woman and the society that is significant and is, in this model, a product of the cultural context.

How does this particular map of the 'PMS' experience accord with the map of the narrator's theory? The significance of the cultural context is viewed as essential in both. That societies respond to this experience in a fashion shaped by the culture itself is also advocated in both. That premenstrual syndrome is at least partially a reflection of some women's response to living in a patriarchal culture is supported in both.

The striking similarity between these two maps, even though they come from different disciplines and utilize different research methods, supports the theory advanced in this thesis that premenstrual syndrome--as it is experienced by actual women living in today's world--can only be adequately understood if it is viewed in terms of the cultural context.

9. EPILOGUE

Implications for Healing From Pain

Many of the implications for assisting in the healing process have been discussed--albeit briefly--in the Feminist Perspective of the Discussion chapter. Furthermore, the insistence throughout this thesis--torturous as it may have made the route--that women's experience of pain be viewed through the context and conditions of the Western culture, is itself a deliberate attempt to offer an essential perspective to women's healing.

If women's lives, and the pain that they experience, as they live their lives, is not viewed in the context of being a female member of a patriarchal culture, then the road to women's healing will indeed be more tortuous and circuitous than the cultural roadmap the reader has been asked to follow.

The constant references to conditions and contexts have been one of the gifts I felt it appropriate to offer both those who offer assistance along a healing journey, and to those who seek to find their unique healing pathways. If all of us--women and men--who are committed to assisting others as they travel the journey are not sustained in the time-consuming, exhausting process of learning the specific conditions and contexts of the individuals who seek our assistance, then the healing process becomes much more difficult.

In addition to learning the specific conditions and contexts of each individual's pain, it is incumbent upon the healers to travel through the conditions and contexts with the individual and to offer a healing perception which will allow the barriers to the expression of the inner self to ease away. Then, the infinitely precious inner self can be accessed, reclaimed, valued, and honored.

I feel very privileged to have been provided with the opportunity to record the story of the women who shared their lives with me. I offer this recording of their story as a gift to women in the midst of pain: healing from the inside-out is possible, even after the most exhausting outside-in cures have failed. Hope of healing is not linear: there is no point of no return, and the turning point of healing may yet be found, no matter how long the journey.

It is hoped that this work will enable women in pain and the healers who assist them to seek rituals of menstrual celebration. An exquisite celebration of women's menstruation is offered in the _Red Flower_ by Dena Taylor, and it is hoped that from it women will create rich traditions for themselves and for their daughters.

Just as each healer carries the tremendous responsibility for enabling the awareness of individual contexts and conditions that affect those who are healing, each healer also carries the enormous burden of assisting both women and men to understand the cultural conditions and contexts that are intimately connected with their pain.

Why? Ask any woman who has ever experienced the pain of premenstrual chaos! Ask any compassionate man who has tried, and felt helpless, to help her! Ask any woman who has experienced terrible depersonalization in the often dehumanizing conditions which may be imposed by modern medical technology! Ask any man who has been reduced to standing by helplessly, kept ignorant of what her birthing body, mind, and spirit needed from him! Ask any woman who--for whatever reasons--felt her unborn child torn from her! Ask any man who has had no way to know how to help her, nor to begin his own healing process from this experience!

It is my hope that the knowledge of human experience gained along the road I have presented will assist women and men to travel on their unique healing journey. It is also offered as a gift from these women, to the healers who empower those with whom they walk the journey of healing.

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APPENDIX

Table 4

Informed Consent

UNIVERSITY OF ALBERTA
FACULTY OF EDUCATION

Informed Consent Form

PROJECT TITLE: The Experience of Premenstrual Changes
INVESTIGATOR: Robyn Mott Phone:432-5205
463:8763

The purpose of this research project is to increase understanding of women's experience of premenstrual changes. Interviews will be conducted at least twice and each interview will last approximately one hour. During these interviews you will be asked questions about personal experiences. Interviews will be audiotaped.

There may be no direct benefits to the participants of this study, but it is hoped that the information they share will be helpful to other women.

THIS IS TO CERTIFY THAT I,______________________________ HEREBY agree to participate as a volunteer in the above named research study.

I understand that there will be no health risks to me resulting from my participation in the research.

I hereby give permission to be interviewed and for the interviews to be tape-recorded and subsequently transcribed into written form using a pseudonym.

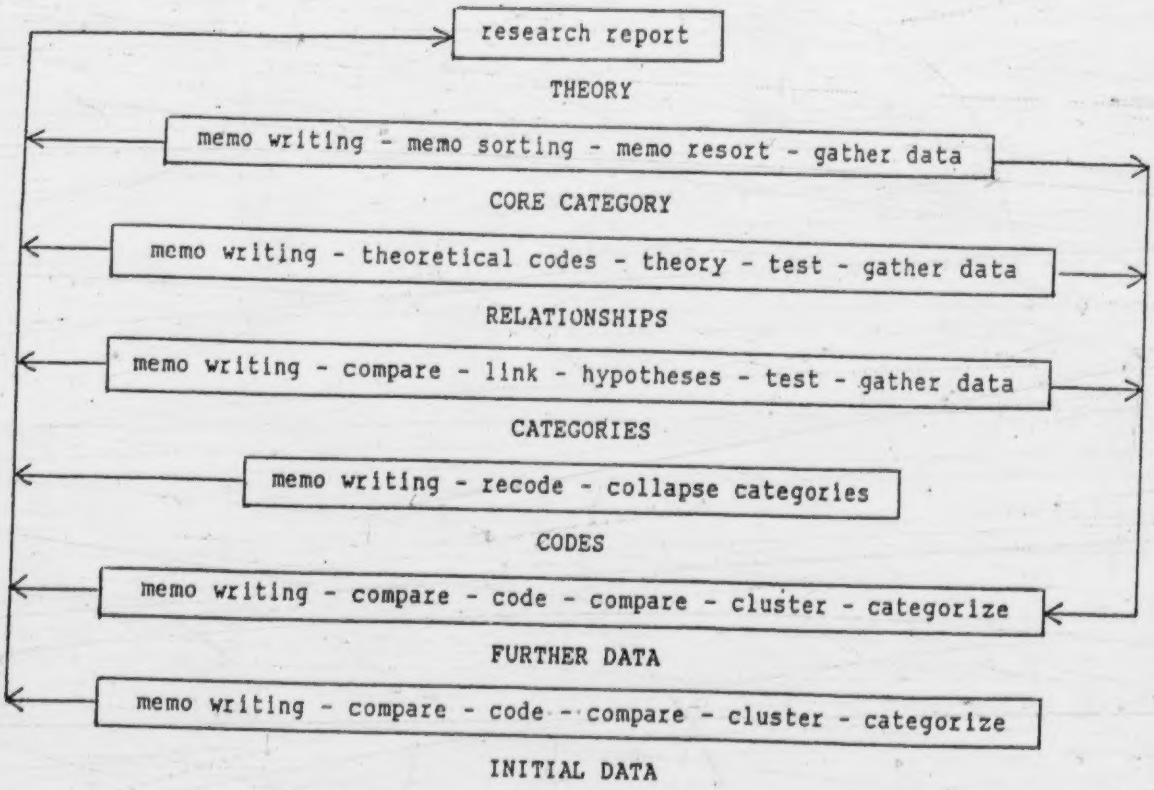
I understand that at the completion of the research the tapes will be erased. I understand that the information may be published, but my name will not be associated with the research.

I understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire, and all questions have been answered to my satisfaction.

________________________ ________________________ Participant
Researcher Date

Figure 1. The steps of grounded theory research, showing the process involved and the hierarchical level of abstractions.


research report
THEORY
memo writing - memo sorting - memo resort - gather data
CORE CATEGORY
memo writing - theoretical codes - theory - test - gather data
RELATIONSHIPS
memo writing - compare - link - hypotheses - test - gather data
CATEGORIES
memo writing - recode - collapse categories
CODES
memo writing - compare - code - compare - cluster - categorize
FURTHER DATA
memo writing - compare - code - compare - cluster - categorize
INITIAL DATA